HEALTH INVENTORY

This health inventory is designed for you and members of your health care team with whom you wish to share it. Answering the questions as thoroughly as possible will provide insight into your current health status. Pulling all this information together helps one to see patterns and tendencies. The information is confidential and will not be released to any person without your request.

Date: _____

Name _____ Age _____ Birth date _____

Address: _____

Home Phone: _____ Work Phone _____

Height: _____ Weight: _____ 1 year ago _____ 5 years ago_____

Occupation:_____ Full time_____ or Part time_____

Living situation: ☐ Alone ☐ Friends ☐ Partner ☐ Spouse ☐ Parents ☐ Children ☐ Pets

Names and ages of those living with you: _____

_____

What are your major health concerns and intentions for your visit today?

_____

_____

Please list any other health care providers or consultants you are currently working with:

_____

_____

Would you like any of them to receive a copy of your recommendations? _____

Please list all herbs, vitamins, and dietary supplements you currently take, citing brand name whenever possible: (use additional space on back if needed)

PRODUCT **DOSAGE** **FREQUENCY (NUMBER/ DAY)**

_____

_____

_____

List all medications you are currently taking (including aspirin, antacids, etc.) indicating whether they are over the counter (OTC) or Prescribed (P). Use additional space on back if needed.

PRODUCT **OTC OR P?** **DOSAGE** **FREQUENCY (NUMBER/ DAY)**

_____

_____

_____

List all medications, herbs, etc., to which you have a known allergy:

_____

_____

_____

DIETARY INFORMATION

Describe below your typical meals. Please be as specific as possible. For example, instead of "oil" list type of oil, such as olive, corn, etc. Instead of ''bread" list whether white or whole grain, etc. Instead of "vegetables" list the type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include all beverages, type and quantity (two cups of coffee, one glass of orange juice, etc.)

Breakfast: _____

_____

Morning snack(s): _____

Lunch: _____

_____

Afternoon snack(s): _____

Dinner: _____

_____

Daily water consumption (number of glasses/day) :_____

Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.):

_____

Please list any known food allergies/sensitivities:

FOOD **DESCRIBE REACTION**

_____

_____

FAMILY HISTORY

Please describe any relevant or major health related issues: (alcoholism, high blood pressure, cancer, diabetes, heart disease, psychiatric illness, osteoporosis, other addictions, other illnesses)

Mother: _____

Father: _____

Sister(s) _____

Brother(s) _____

Maternal Grandmother _____

Maternal Grandfather _____

Paternal Grandmother _____

Paternal Grandfather _____

Other family members with pertinent issues, or recurring family health trends: _____

_____

_____

PAST HEALTH PROBLEMS

List all major health problems including any operations.

PROBLEM **YEAR**

_____

_____

_____

GENERAL HEALTH

Cardiovascular

___High blood pressure
___Low blood pressure
___Pain in heart
___Poor circulation
___Swelling
___Stroke/murmur

Skin

___Boils
___Bruises
___Dryness
___Itching
___Varicose veins
___Skin eruptions

Muscles/Joints

___Backache
___Broken bones
___Mobility
___Arthritis
___Bursitis
___Weakness

Respiratory

___Chest pain
___Difficulty breathing
___Cough
___Tuberculosis
___Congestion
___Wheezing
___Asthma
___Coughing up blood

Urinary/Kidney

___Excessive urination
___Water retention
___Burning urine
___Kidney stones
___Lower back pain
___Dark circles/under eyes
___Itchy ears/eyes
___Blood in urine

Gastro-Intestinal

___Belching
___Colitis
___Constipation
___Abdominal pain
___Liver problems
___Gall stones
___Ulcers
___Transit time

Eyes, Ears, Nose and Throat

___Failing vision
___Sinus congestion
___Hearing loss
___Ear aches
___Hay fever
___Sore throat
___Canker sores
___Eye pains
___Sinus infection
___Tonsils
___Nose bleeds

General

___Fatigue
___Excessive thirst
___Difficulty sleeping
___Night sweats
___Loss of appetite
___Frequently colder or warmer than others
___Fever
___Always hungry

Male Reproductive

___Burning/discharge ___Lumps/swelling of testicles
___Painful testicles ___Vasectomy

Female Reproductive

___Age of first period ___Regular ___Length of cycle
___Heavy bleeding ___Clots ___Pains/cramps
___Vaginal discharge ___Color/amount ___Vaginal itching
___Painful intercourse ___Cervical dysplasia ___Pelvic pain
___Breast pain ___Breast lump ___Anemia
___Infertility ___Genital herpes ___Hot flashes
___Mood Swings ___Dry vaginal lining ___Osteoporosis

Contraceptive/Pregnancy History

___BC Pills ____Rhythm ___IUD
___Diaphragm ____Condoms ___Mucous method
___Cervical Cap ____Spermicides ___Fertility lens

Please list each pregnancy you have had, including miscarriages and abortions:

_____

_____

CURRENT STATE OF EMOTIONS AND SPIRITUAL WELL-BEING

Take time to think about and answer the following questions:
Are you completely satisfied with your living conditions?
Are you able to express your feelings and emotions?
Is there an excess of stress in your life? What is causing the stress?
Are you satisfied with your job?
If in a relationship, are you satisfied with it? Are you lonely?
Is there something you would like to change in your life? Can you change it?
Are you a "nervous type" of person? What type of things make you nervous?
Do you sleep well? How many hours (in a 24-hour period)?
Do you dream? Do you remember your dreams?
Are you satisfied with your energy level? Do you often feel exhausted?
Is it easy to wake up in the morning?

Do you enjoy your work?

Do you have hobbies/activities you enjoy outside of work?

Which of these feelings dominate your life?

Joy Happiness Anger Sadness Fear Sympathy Worry Depression Other

Do you believe in a higher power? Are you at peace with this belief/ relationship?

Please list approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, loss of lover, loss of job, change of residence, injury, death of a loved one, etc.)

YEAR **EVENT**

_____

_____

_____

LIFESTYLE HABITS

Routine physical exercise: Type of exercise_____

For how many minutes _____How often?_____

Tobacco use: How much? _____ Previously?_____

Alcohol use: How much?_____ How often? _____

Caffeine use: How much?_____ How often? _____

Mood altering substances (such as cocaine, marijuana, etc.):

How much? _____ How often? _____

How many hours of television do you watch in a week? _____

Please use this space to add any other information about yourself that you think will be helpful:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____