HEALTH QUESTIONNAIRE

Welcome to **Alaska Natural Health Solutions**! Our intention here is to get a complete picture of your health history and lifestyle choices. We understand that this form is time consuming and appreciate your patience. Be as accurate and honest as you can. Some of these questions are of a personal nature: please be assured this information will be protected with the strictest confidentiality. Please let us know if you find any of the questions needing clarification. When you finish, please let the reception staff know.

Health Concerns:

1. What is your primary health concern?

2. How long has this problem been present? How frequent? How severe?

3. Where in your body do you experience this problem? Any change of location since it began?

4. Has the problem gotten better or worse or changed with time? In what way?

5. Are there any associated symptoms or problems?

6. What treatments have been tried so far (either your own efforts or those of a health care professional)? Any response?

7. What do you hope to accomplish with this evaluation/consultation?

Other current health problems:_____
_____

Your Past Medical History (please include dates)
Significant illness:___ Addiction ___ Cancer ___Depression ___ Diabetes ___Fatigue ___Fibromyalgia ___High blood Pressure ___Heart ___Hepatitis ___Rheumatic Fever ___Seizure ___Thyroid Disease ___Other
Details: _____
_____

Other Serious Health Problems:_____
_____

Current Medications: (please include name, dose, how often you take it, how long, who prescribed it)
_____
_____
_____

Allergies: (include name of drug and type of reaction) _____

_____

Family Medical History: ___ Addiction ___ Cancer ___Depression ___ Diabetes ___Fatique ___Fibromyalgia ___High blood Pressure ___Heart ___Hepatitis ___Rheumatic Fever ___Seizure ___Thyroid Disease ___Other

Details: _____

More about you: ____tobacco how much for how long_____

Alcohol: How much how often/types _____

Recreational drugs: as above _____

Use seat belts? _____ Smoke alarm in working orders? _____ Bike helmet?_____

Typical Diet: Breakfast:

Snack –

Lunch –

Snack –

Dinner –

Supplements:_____

Sleep:_____

Exercise:_____

Caffeine:_____

Relationships: Marital status:_____

Children? Name ages, quality of relationship:_____

_____

Family of origin. As above:_____

_____

Intimate relationship positive overall?_____

Sexual relationship satisfying?_____

Community:_____

Hobbies: _____

Employement:_____

Relaxation, Meditation: _____

Spiritual Pursuits:_____

Current symptom review: Please circle all that apply to you currently:

GEN: Fatigue, weight changes, appetite changes, muscle weakness, bleeding, fever, chills, recent trauma or infections

HEENT: Vision changes, hearing changes, nose bleeds, unsual sneezing, nasal congestion, runny nose, sore throat, swallowing difficulties, ear pain, facial pain.

NECK: neck pain, swelling, or stiffness

LUNGS: cough, short of breath, need to sit upright to breathe, or coughing up blood.

HEART: palpitations, extra or skipped beats, chest pain, high blood pressure.

GI: abdomen pain, excessive burping, heart burn, nausea, vomiting, vomiting blood, diarrhea, constipation, greasy stools, black stools, or passing excess gas.

GU: recent pain with urination, urine frequency, urine hesitancy, urine urgency, urine flow-slow, urine retention, getting up at night to urinate, dark urine, or losing urine when you don't mean to, low sex drive, erectile dysfunction.

BJE: joint pain, joint stiffness, back pain, muscle cramps, or muscle pain.

SKIN: rash, lesion, unable to sweat, bruising, itching, changes in moles or freckles.

NEURO: memory loss, disorientation, fainting, double vision, dizziness, vertigo, clumsiness, numbness, tingling or burning sensations, head pain, headache

MOOD: anxiety, depression, panic attacks