Health History Inventory

Name:_____ **Date:** _____

Please put an "X" mark in the boxes below for those items that apply to you.

1. Health History: Have you *ever* been diagnosed with any of the following disorders?

- ❑ Tension Headaches
- ❑ Migraine Headaches
- ❑ Chronic Back Pain or Sciatica
- ❑ TMJ Disorder or Jaw Pain
- ❑ Chest Pain or Angina
- ❑ Arthritis or Aching Joints
- ❑ Fibromyalgia or Muscle Aches
- ❑ Chronic Fatigue Syndrome
- ❑ Carpal Tunnel Syndrome
- ❑ Neuropathy or Neuralgia
- ❑ Shingles (Herpes Zoster)
- ❑ Dermatitis, Eczema, or Hives
- ❑ Deafness or Hearing Impaired
- ❑ Tinnitus or Ringing in Ears
- ❑ Blurry or Impaired Vision
- ❑ Hypertension / High Blood Pressure
- ❑ Coronary Disorder or Heart Attack
- ❑ Kidney Disorder or Kidney Stones
- ❑ Urinary or Bladder Disorder
- ❑ Gall Bladder Disorder or Gall Stones
- ❑ Liver Disease or Hepatitis
- ❑ Asthma, Bronchitis, or Emphysema
- ❑ Pneumonia or Tuberculosis
- ❑ Allergies or Hayfever
- ❑ Irritable Bowel Syndrome or Colitis
- ❑ Hemorrhoids or Hernia
- ❑ Dysmenorrhea or Irregular Menses
- ❑ Peri-Menstrual Syndrome
- ❑ Menopausal Problems or Hot Flashes
- ❑ Prostate or Genital Disorder
- ❑ Cancer
- ❑ Stroke
- ❑ Concussion or Head Trauma
- ❑ Brain Seizures or Epilepsy
- ❑ AIDS or HIV Disease
- ❑ Sexually Transmitted Disease
- ❑ Diabetes Mellitus
- ❑ Thyroid Disorder
- ❑ Anorexia or Bulimia
- ❑ Attention Deficit Disorder
- ❑ Panic Attacks or Phobias
- ❑ Depression or Bipolar Disorder
- ❑ Physically Abused as a Child
- ❑ Alcohol Abuse Problems
- ❑ Substance Abuse Problems

2. Accidents: Have you *ever* been left injured or impaired by any of the following types of accidents?

- ❑ Automobile Accident
- ❑ Work-Related Accident
- ❑ Athletic Injury

3. Current Conditions: In the *past 3 months*, have you been bothered by any of the following experiences?

- ❑ Pain in Upper or Lower Limbs
- ❑ Stiff, Aching, or Swollen Joints
- ❑ Cold Hands or Cold Feet
- ❑ Teeth Grinding at Night
- ❑ Insomnia or Difficulty Sleeping
- ❑ Disturbing Dreams
- ❑ Snorring or Sleep Apnea
- ❑ Coughs or Difficulty Breathing
- ❑ Dry Mouth or Frequently Thirsty
- ❑ Dry Skin or Skin Irritation
- ❑ Dry Eyes or Eye Irritation
- ❑ Aversive to Cold Temperatures
- ❑ Overweight by more than 20 pounds
- ❑ Underweight by more than 10 pounds
- ❑ Diarrhea or Loose Stools
- ❑ Constipation or Dry Stools
- ❑ Stomach Heartburn or Indigestion
- ❑ Frequent Urination
- ❑ Craving for Sweets or Chocolate
- ❑ Poor Memory or Foggy Headed
- ❑ Dissatisfied with Job
- ❑ Lack of Affection from Others
- ❑ Relationship Problems
- ❑ Felt Life has Little Meaning or Purpose
- ❑ Frequent Colds or Flu Illnesses
- ❑ Night Sweats
- ❑ Often Lethargic or Tired
- ❑ Unable to Relax
- ❑ Low Sex Drive
- ❑ Sex Life Not Satisfying
- ❑ Worried about Finances
- ❑ Bored or Uninterested in Things
- ❑ Argumentative with Others
- ❑ Difficulty in Confronting Others
- ❑ Used Recreational Substances
- ❑ Thoughts of Ending Your Life

4. Substances or Medications: In the *past 3 months*, have you taken any of the following items?

- ❑ Several Cups of Coffee per day
- ❑ Several Cigarettes per day
- ❑ Several Alcoholic Drinks per day
- ❑ Several Aspirin or Tylenol Pills per day
- ❑ Prescribed Pain Relieving Medication
- ❑ Blood Pressure Medication
- ❑ Sleeping Pills
- ❑ Anti-Anxiety Medication
- ❑ Anti-Depressant Medication

5. Health Care Professionals: In the *past 12 months*, have you seen any of the following for a session or visit?

- ❑ Psychotherapist or Counselor
- ❑ Psychiatrist
- ❑ Medical Doctor or Nurse
- ❑ Dentist or Dental Hygenists
- ❑ Chiropractic Doctor
- ❑ Acuncturist or Herbalist