



Optimal Health & Wellness Center, Ltd.

Patient Health History:

Name: _____ Date of Birth: _____ Today's Date: _____

Occupation: _____ Age: _____ Height: _____ Sex: _____ Number of Children: _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? Y N Are you pregnant? Y N

Reason for office visit: _____ Date began: _____

Date of last physical exam: _____ Practitioner name and phone number: _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis)

Outcome: _____

What types of therapy have you tried for this problem(s): diet modification fasting vitamins/minerals herbs
 homeopathy chiropractic acupuncture conventional drugs none other: _____

List current health problems for which you are being treated: _____

Current medications (prescription or over-the-counter): _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year:	Operation, Illness, Injury:	Outcome:
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? Y N

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents), or health and/or life threatening activities (e.g., fireman, farmer, hair stylist)? Y N _____

I have: Corrective lenses Dentures Hearing Aid Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: see hear taste smell feel hot/cold sensations

move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong **like** for any of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Strong **dislike** for any of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Do you: prefer warmth (i.e., food, drinks, weather, etc.) prefer cold (i.e., food, drinks, weather, etc.) no preference

Is your sleep disturbed at the same time each night? Y N if yes, what time? _____

Time of day you feel the most energy or the least symptoms:

7 a.m.—9 a.m. 9 a.m.—11 a.m. 11 a.m.—1 p.m.

1 p.m.—3 p.m. 3 p.m.—5 p.m. 5 p.m.—7 p.m.

7 p.m.—9 p.m. 9 p.m.—11 p.m. 11 p.m.—1 a.m.

1 a.m.—3 a.m. 3 a.m.—5 a.m. 5 a.m.—7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

7 a.m.—9 a.m. 9 a.m.—11 a.m. 11 a.m.—1 p.m.

1 p.m.—3 p.m. 3 p.m.—5 p.m. 5 p.m.—7 p.m.

7 p.m.—9 p.m. 9 p.m.—11 p.m. 11 p.m.—1 a.m.

1 a.m.—3 a.m. 3 a.m.—5 a.m. 5 a.m.—7 a.m.

Do you experience any of these general symptoms EVERY DAY?

Debilitating fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation

Depression Panic attacks Nausea Fecal incontinence Bleeding

Disinterest in sex Headaches Vomiting Urinary incontinence Discharge

Disinterest in eating Dizziness Diarrhea Low grade fever Itching/rash