BioEnergetic Health™, LLC
3845 1st St Dr NW, Hickory, NC 28601
828-855-2994

HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of first visit: _____

Date of birth: _____ Age: _____ Gender: M / F

Mother's name if minor: _____Father's name if minor: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Other

Street Address, City, ST, Zip: _____

Phone: (h) _____ (w) _____ (c)_____

E-mail: _____

Occupation: _____ Employer: _____

Emergency contact: _____Relation: _____ Phone: _____

Primary Care Physician (Name/Phone): _____

Referred by: _____ How did you hear about us? _____

MAIN PROBLEM: Please describe the health concern you wish to address

When did this problem begin? _____

What other treatment(s) have you tried? _____

MEDICAL HISTORY
Please circle all that apply:

Anemia *Arthritis* *Asthma* *Allergies* *Bronchitis/Pneumonia* *Cancer*

Contagious Illness *Diabetes* *Epilepsy/Seizures* *Hepatitis* *Heart Disease* *Diabetes*

Hemophilia *High Blood Pressure* *HIV/AIDS* *Mental Illness* *Osteoporosis*

Thyroid Disease *Venereal Disease* *Other:* _____

Surgeries & Dates: _____

Significant Traumas (falls, accidents, etc.): _____

Location of scars: _____

Allergies: *see Allergy Questionnaire - attached*

LIFESTYLE

Please describe your average daily diet:

Morning	**Afternoon**	**Evening**

How many cups/week do you drink: Alchohol _____ Coffee _____ Soda _____ Water _____

Cigarette use (please circle): Past use Current use

Have you ever taken illicit drugs or prescription medication for non-medical use? If so, what and when: _____

_____

Do you have a regular exercise routine? Y N If yes, please describe: _____

Describe your spiritual practice: _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Rate your average energy level on a scale of 1-10 (1=can barely get out bed; 10=unlimited energy): _____

My energy level is (check all that apply): ○Low in the morning ○ Low in the evening ○ Same throughout day

Do you enjoy work? Y N Why/Why not? _____

Rate your average stress level on a scale of 1-10 (1=very little stress; 10=constant stress): _____

How do you relieve your stress: _____

How many times in a week do you feel the following:

Irritable_____ Anxious_____ Guilt_____ Depression_____ Overjoyed_____

Angry_____ Worry_____ Fear_____ Sadness_____ Grief_____

Are you currently taking any medications for anxiety or depression? Please list:

Please list all prescription medications you are currently taking, over the counter drugs, supplements & herbs:

Medication/Drugs/Supplements/Herbs	Reason for Use

Name: _____ Date: _____

Instructions: Indicate the symptoms which apply to you using the following scale
(0) If "never" (1) if "rarely" (2) if "time to time" (3) if "often"

Gastrointestinal

____ Lower bowel gas several hours after eating
____ Burning stomach sensation, eating relieves
____ Coated tongue
____ Indigestion ½-1 hr after eating (maybe to 3-4hrs)
____ Carbonated drinks 3+ per week?
____ Difficult bowel movements
____ Ulcers?/Colitis?/Gastritis?
____ Stomach bloating after eating
____ Nausea/Vomiting
____ Hemorrhoids
____ Excessive belching/burping
____ Bad breath
____ Alternating diarrhea/constipation
____ Blood in stools
____ Have pets eg. dogs, cats, farm animals, etc.
____ Rectal itching/pain
____ Can't gain weight
____ International travel
____ Stomach/intestinal cramping/diarrhea
____ Other g.i. problems?

Total: ____

Sugar Handling Problems

____ Afternoon headaches
____ Get "shaky" if hungry
____ Faintness if meals delayed
____ Heart palpitations if meals missed or delayed
____ Eat when nervous
____ Awaken after few hours of sleep
____ Hard to get back to sleep
____ Crave candy or coffee in afternoon
____ Abnormal craving for sweets or snacks
____ Thirsty much of the time
____ History of diabetes
____ Excessive frequent urination
____ Blurred vision/failing eyesight
____ Breath smell sweet
____ Tingling, numbness, prickling sensation in extremities

Total: ____

Cardiovascular

____ Bruise easily, "black & blue spots"
____ Sigh frequently
____ Aware of "breathing heavily"
____ Open window in closed room
____ Susceptible to colds & fevers
____ Swollen ankles, worse at night
____ Muscle cramps, worse during night
____ Shortness of breath on exertion
____ Nosebleeds
____ Ringing in the ears
____ Heart palpitations / Irregular heartbeat
____ Dull pain in chest or radiating into left arm, worse on exertion
____ High blood pressure
____ Low blood pressure
____ Hands & feet go to sleep easily
____ Numbness in extremities
____ Tendency to anemia
____ Tension under breastbone or feeling of tightness, worse in exertion
____ Blushing with no apparent cause
____ Black stool (no iron supplementation)
____ Poor concentration
____ Slurred speech
____ Headaches
____ Weakness / fatigue
____ Out of breath frequently e.g. going up stairs
____ Nervousness
____ Varicose veins
____ Blood clots

Total: ____

Neurological

____ Seizures
____ Stroke
____ Concussion
____ Poor memory
____ Tremors (where?)
____ Lightheaded/Dizziness
____ Any other neurological problems?
____ Loss of balance
____ Lack of coordination
____ Weakness
____ Areas of tingling/numbness
____ Headaches
____ Migraines

Total: ____

Genitourinary

____ Frequent urination
____ Urgency to urinate
____ Unable to hold urine
____ Any particular color to your urine?
____ Do you wake up to urinate? How often?
____ Any other problems with your urinary system?
____ Pain upon urination
____ Blood in urine
____ Decrease in flow
____ Kidney stones
____ Kidney infection

Total: ____

Liver & Gall Bladder

____ Pain under right side of rib cage
____ Frequent skin rashes
____ Bitter metallic taste in mouth in morning
____ Bowel movements painful and difficult
____ Low energy, weakness, exhaustion
____ Upset from greasy/fatty foods
____ Bruises easily
____ Frequent headaches
____ Stools light colored
____ Pain between shoulder blades
____ Laxatives used often
____ History of gall bladder attacks or gallstones
____ History of hepatitis
____ History of jaundice
____ Sneezing attacks
____ Itchy skin, worse at night
____ Dry flaky skin, hair
____ General feeling of poor health
____ Aching muscles
____ Swollen feet and/or legs

Total: ____

Thyroid

____ Impaired hearing
____ Decrease in appetite
____ Ringing in ears
____ Constipation
____ Puffy hands/face
____ Tired/sluggish
____ Miscarriages
____ Infertility
____ Mental sluggishness/forgetfulness
____ Headaches upon rising; wears off during day
____ Slow pulse, below 65
____ Cold hands/feet
____ Gains weight easily
____ Weight gain around hips
____ Outer third eyebrow thinning
____ "Emotional"
____ Flush easily
____ Night sweats
____ Hair loss

Total: ____

Bone Development / Minerals, ETC

____ Hip and joint pain
____ Receding gums and/or dental cavities
____ Tendency towards slouching/weak
____ Bone loss/osteoporosis in family
____ Crunching, creaking joints

Total: ____

Environmental

____ Exposure to fumes e.g. paint, salon, car
____ Use of pesticides on garden
____ Live near power lines/high tension wires
____ Have mercury amalgams (silver) in mouth
____ Skin disorders e.g. psoriasis, eczema etc.
____ Loss of hair
____ Hormone disorders
____ History of cancer/personal or familial

Total: ____

Muscle & Ligament

____ Muscle aches, stiffness, cramping and pains
____ Chiropractic adjustments don't hold
____ Whiplash and/or ligamental trauma/strain
____ Fatigue, sluggishness
____ Upper or lower back pain
____ Stiff neck and shoulders

Total: ____

Adrenal

____ Low blood pressure
____ Chronic fatigue
____ Low energy, lack of stamina
____ General malaise, unhappiness
____ Tendency to hives
____ Arthritic tendency
____ Excessive perspiration
____ Colds/flu often
____ Weakness after illness
____ Dark circles under the eyes
____ Crave salty foods
____ Feeling unrefreshed upon wakening
____ Allergies
____ Exhaustion – muscular & nervous
____ Respiratory disorders
____ Swollen ankles
____ Dizzy when stand up "too fast"
____ Decreasing appetite
____ Irritable
____ Bright lights irritate

Total: ____

Immune

____ Throat infections
____ Poor wound healing
____ Slow to recover from cold or flu
____ Gets boils or sties
____ Swollen lymph glands
____ Catch colds or flu easily
____ Bumpy skin on arms
____ Inflamed or bleeding gums
____ Cough with mucus
____ Swollen tongue
____ Dark areas under the eyes/cheeks
____ Sore throat
____ Post nasal drip
____ Ear aches and infections
____ Herpes/cold sores

Total: ____

Lung

____ Chronic cough
____ Pain around ribs
____ Pain with a deep breath
____ Shortness of breath
____ Chest pain
____ Difficulty breathing
____ Post nasal drip
____ Sinus and nasal congestion
____ Coughing up phlegm
____ Coughing up blood
____ Bronchitis (frequent)
____ Infections settle in lungs
____ Sensitive to smog
____ Asthma
____ Wheezing
____ Smoker
____ Chronic lung congestions
____ Breathes through mouth
____ Shallow breather

Total: ____

Kidneys

____ Frequent urination
____ Rose-coloured (bloody urine)
____ Dripping after urination
____ Difficulty passing urine
____ Cloudy urine
____ Rarely need to urinate
____ Frequent bladder infections
____ Painful/burning when urinating
____ Urination when cough or sneeze
____ Strong smelling urine
____ Mild back pain
____ Interrupted urine stream
____ Tingling in joints
____ Joint and muscle pain/cramping
____ Can't hold urine
____ Dark circles under eyes
____ Frequent urge to urinate but passes only small amounts

Total: ____

Men's Health

____ Tired too easily
____ Urination difficult
____ Night urination frequent
____ Pain on inside of legs or heel
____ Impotence
____ Premature ejaculation
____ Any other reproductive problems?
____ Testicular pain/injury/cancer
____ Sores on genitals
____ STDS's
____ Feeling of incomplete bowel evacuation
____ Prostrate trouble
____ Leg nervous at night
____ Diminished sex drive

Total: ____

Women's Health

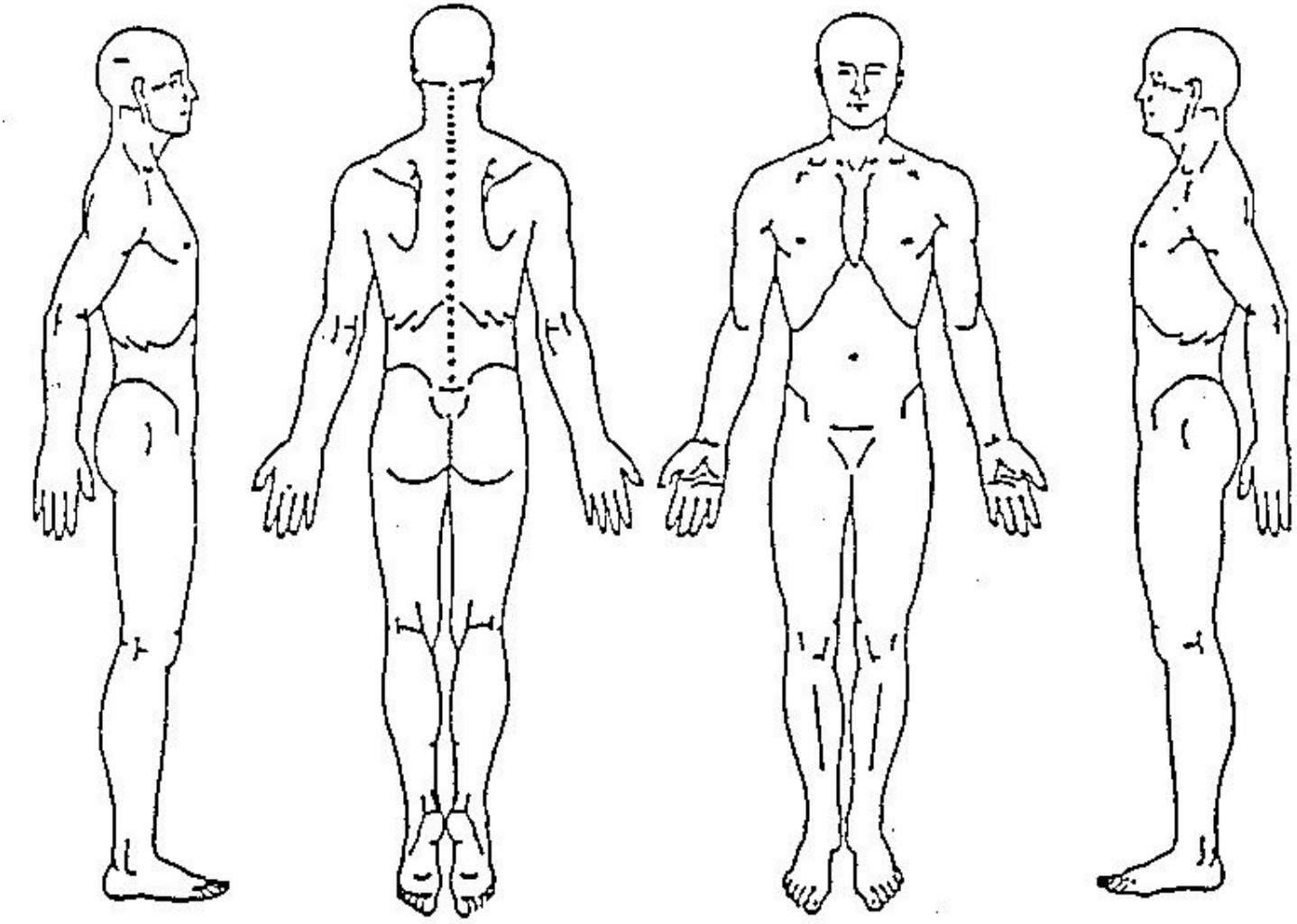
____ Are you pregnant?
____ Painful menses
____ Premenstrual tension
____ Very easily fatigued
____ Depressed feeling
____ Menstruation excessive and prolonged
____ Painful breasts (monthly)
____ Infertility
____ Lumpy breasts/worst at menses
____ Have taken birth control pills
____ Menopause, hot flashes, etc.
____ Menses scanty or irregular
____ Acne, worse at menses
____ Vaginal discharge/yeast, etc.
____ Sores on genitals
____ STD's

Total: ____

PLEASE CIRCLE YOUR LEVEL OF DISCOMFORT ON THE SCALE BELOW

No discomfort 1 2 3 4 5 6 7 8 9 10 Worst

Pain assessment. Please circle the areas where you are currently experiencing pain:



Other concerns: _____

Patient Signature: _____ Date: _____