

**G L E N V I E W   H E A L I N G   A R T S   C E N T E R**  
**H E A L T H   Q U E S T I O N A I R E**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ Sex \_\_\_\_\_

Marital Status \_\_\_\_\_ No. of Children \_\_\_\_\_ Occupation \_\_\_\_\_

E-mail address \_\_\_\_\_ Referred by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Their Phone Numbers \_\_\_\_\_ Their Address \_\_\_\_\_

Primary Care Practitioner: \_\_\_\_\_

What are the main problems you would like us to help you with?

When and how did they develop?

Have you ever had a similar problem before? \_\_\_\_yes \_\_\_\_no

If yes, please explain:

Have you been given a diagnosis for this problem? \_\_\_\_yes \_\_\_\_no

If yes, what was the diagnosis?

Have you received treatment for this problem? \_\_\_\_yes \_\_\_\_no

If yes, when and by whom?

What were the results of this treatment?

Have you experienced any injuries related to this problem? \_\_\_\_yes \_\_\_\_no

If yes, please explain:

What makes the problem better or worse?

List additional physicians you are seeing:

To what extent does this problem interfere with your: (0=not at all, 5=greatly)

\_\_\_\_home life \_\_\_\_work life \_\_\_\_social life \_\_\_\_ability to exercise \_\_\_\_rest/sleep \_\_\_\_other

Please explain:

Occupational stress? (Please circle) chemical    physical    psychological

Please explain:

Where do you work? \_\_\_\_ indoors    \_\_\_\_ outdoors

Average Daily Diet:

Types and amount of liquid intake per day?

Do you skip any meals? If so, please explain.

Are you now or ever been on a (physician or self prescribed) restricted diet?  
(i.e., diabetic, vegetarian, high protein, low carbohydrate) If so, what kind?

Habits:

Do you exercise? If so, how much and what kind?

Do you smoke? If so, what do you smoke and how much?

Medicines taken within the last two months (including pharmaceuticals, vitamins, over the counter drugs or herbs)

Do you have Allergies (drugs, chemicals, foods, substances)? Types of reaction?

How many hours do you sleep on average? \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

Past Medical History (please include when the diagnosis was established)

Significant Illness:

\_\_\_ Cancer \_\_\_ Diabetes \_\_\_ Hepatitis \_\_\_ Thyroid Disease \_\_\_ Heart Disease  
\_\_\_ Fibromyalgia \_\_\_ Arthritis \_\_\_ Tuberculosis \_\_\_ Hypertension \_\_\_ Anemia  
\_\_\_ Emotional Imbalance \_\_\_ Breathing Problems \_\_\_ Allergies \_\_\_ Seizures  
\_\_\_ Digestive Disorders \_\_\_ HIV/AIDS \_\_\_ Venereal Disease \_\_\_ Other-explain

Family Medical History (please specify family member)

\_\_\_\_\_ Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Hepatitis \_\_\_\_\_ Hypertension  
\_\_\_\_\_ Heart Disease \_\_\_\_\_ Stroke \_\_\_\_\_ Asthma \_\_\_\_\_ Allergies  
\_\_\_\_\_ Auto-Immune \_\_\_\_\_ Alcoholism \_\_\_\_\_ Miscarriage \_\_\_\_\_ Other

**Injuries-** List all serious injuries and dates they occurred:

**Surgeries-** List all surgeries and date they occurred:

Have you ever been hospitalized for any other reason?

**Please note:**  
**Circle current conditions**  
**and check mark former**  
**conditions**

**General Symptoms**

- Tremors
- Headache
- Fever
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Depression
- Weight loss
- Forgetfulness
- Numbness or pain in arms, hands, joints, legs or feet
- Confusion
- Paralysis

**Eyes, Ears, Nose, & Throat**

- Failing vision
- Near sightedness
- Eye pain
- Eye strain
- Cross eyed
- Eye inflammation
- Glaucoma
- Deafness
- Earache
- Hearing loss
- Ear discharge
- Ear noises
- Nose bleeds
- Nasal obstruction
- Nasal drainage
- Loss of smell
- Sinus infection
- Hay fever
- Allergies
- Sore throat
- Hoarseness
- Difficult speech
- Difficult swallowing
- Loss of taste
- Taste changes
- Dental decay
- Gum troubles
- Tonsillitis
- Asthma
- Frequent colds
- Enlarged thyroid
- Enlarged glands

**Skin**

- Skin eruptions
- Clammy skin
- Dryness
- Bruise easily
- Boils
- Rashes
- Sensitive skin
- Hives or allergies

**Respiratory**

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Wheezing

**Cardiovascular**

- Rapid heartbeat
- Slow heartbeat
- Irregular heartbeat
- Pain over heart
- Previous heart stroke
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke
- Varicose veins

**Muscles and Joints**

- Stiff neck
- Pain between shoulders
- Backache
- Painful tailbone
- Foot trouble
- Hernia
- Spinal curvature
- Faulty posture
- Swollen joints
- Stiff joints
- Painful joints
- Arthritis
- Sore muscles
- Weak muscles
- Walking problems
- Sciatica

**Genitourinary**

- Frequent urination
- Scanty urine
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection or stones
- Bed wetting
- Inability to control urine
- Prostrate issues
- Foul smelling urine
- Discolored urine

**Gastrointestinal**

- Poor appetite
- Excessive hunger
- Difficult chewing
- Belching or gas
- Nausea
- Vomiting
- Vomiting blood
- Gas
- Pain over stomach

- Constipation
- Distention of abdomen
- Diarrhea
- Black stool
- Blood in stool
- Colon trouble
- Hemorrhoids (piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis
- Weight trouble

**Female**

- Painful menstrual periods
- Excessive flow
- Hot flashes
- Irregular cycles
- Cramps or backache
- Previous miscarriage
- Vaginal discharge
- Vaginal pain
- Congested breast
- Breast pain
- Lumps in breast
- Menopausal symptoms
- Abnormal bleeding
- Reduced sexual energy
- Pregnancy
- Pregnancy complications

**Male**

- Painful/swollen genitals
- Reduced sexual ability/desire
- Excessive sexual desire
- Weak erection
- Premature ejaculation
- Seminal emission
- Low sperm count
- Impotence
- Frequent masturbation
- Swollen/itching scrotum
- Low sperm count
- Poor morphology
- Poor motility
- Testicular pain
- Urethra pain/discharge
- Genital odor