Bend Community Healing

FIND YOUR FLOW

244 NE Franklin Avenue, Suite 1
Bend, OR 97702 / 541-322-9642

Health History Questionnaire and Registration

Patient Information

Today's Date: ___/___/____

Name: ____
(first) (middle) (last)

Birth date: ___/___/_____ Age: _______

Address: ______________________________________

City: ____________ State: ______ Zip: _________

Cell phone #: __________________________________

Cell phone carrier (for text reminders only): __________

Work phone: ___________________________________

Other/home phone: ______________________________

Email:____

Occupation: ____________________________________

Employer: ______________________________________

How did you hear about BCH? ____________________

____

Emergency contact:

Name: ____

Relationship: ___________________________________

Cell phone: _____________________________________

Would you like to receive our occasional BCH events & health tips/newsletter?

Yes: _____
No: _____

Health History

What are your main reasons for seeking treatment?

1) ______________________________________

2) ______________________________________

3) ______________________________________

How is your sleep? ______________________________

____

How is your digestion? ___________________________

List medications/supplements: ____________________

____

____

List serious illnesses/accidents/surgeries: __________

____

____ Depression
____ Difficulty focusing
____ Dizziness
____ Easily startled
____ Excessive fear
____ Excessive anger
____ Headaches
____ Insomnia
____ Weight gain/loss
____ Nervousness/irritability
____ Feel overwhelmed by life

Check conditions you have/have had in the past:

____ HIV/AIDS
____ Allergies
____ Anemia
____ Arthritis
____ Bleeding disorder
____ Breast lump
____ Cancer
____ Diabetes

Check illnesses that have occurred in relatives:

____ Diabetes
____ Cancer
____ Heart disease
____ High blood pressure
____ Kidney disease

How long has it been since you had a complete medical exam?

Anything else we should know about your health/history?

Health History (cont'd)

Please check symptoms you have/have had in the past year:

MUSCLES/JOINTS/BONES:
____ Tremors or cramps
____ Swollen joints
Pain/weakness/ numbness in:
____ Arms or legs
____ Back or hips
____ Feet
____ Neck
____ Hands
____ Shoulders
____ Other: ______________________________________

EYES/EARS/NOSE/THROAT/RESPIRATORY
____ Asthma/wheezing
____ Blurred or failing vision
____ Difficulty breathing
____ Earache
____ Enlarged glands
____ Eye pain
____ Frequent colds
____ Gum pain/swelling
____ Hay fever
____ Hoarseness
____ Loss of hearing
____ Nose bleeds
____ Persistent cough
____ Ringing in ears
____ Sinus pain/congestion

SKIN
____ Boils
____ Bruise easily
____ Dry skin
____ Itching/rash
____ Sensitive skin
____ Sores that don't heal
____ Sweats

GENITORURINARY
____ Blood/pus in urine
____ Frequent urination
____ Inability to control urine
____ Kidney infection/stones
____ Low libido

CARDIOVASCULAR
____ Chest pain
____ Hardening of arteries
____ High or low blood pressure
____ Poor circulation
____ Previous heart attack
____ Rapid/irregular heartbeat
____ Swelling of ankles

GASTROINTESTINAL
____ Abdominal distension
____ Belching/gas/bloating
____ Constipation
____ Diarrhea
____ Difficulty swallowing
____ Excessive hunger
____ Gallbladder pain or dysfunction
____ Hemorrhoids (piles)
____ Indigestion
____ Nausea
____ Poor appetite
____ Stomach pain
____ Vomiting

IF APPLICABLE:

For women:
____ Bleeding between periods
____ Clots in menses
____ Excessive menstrual flow
____ Extreme menstrual pain
____ Menopausal symptoms
____ PMS
____ Previous miscarriage/abortion
____ Scant menstrual flow

Could you be pregnant? ______________________________

For men:
____ Erectile dysfunction
____ Discharge from penis
____ Prostate enlargement/dysfunction

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature: ____ Date: ____________