



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: _____

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty focusing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Easily startled |
| <input type="checkbox"/> Excessive fear | <input type="checkbox"/> Excessive anger |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Nervousness/irritability |
| <input type="checkbox"/> Feel overwhelmed by life | |

Check conditions you have/have had in the past:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |

Check illnesses that have occurred in relatives:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> 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: _____