Bend Community Healing

155 SW Century Drive, Suite 113, Bend, OR 97702

541-322-9642 www.bendcommunityhealing.com

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 us? _____

_____

Emergency contact :

Name _____

Relationship _____

Cell phone _____

Health History

What are your primary reasons for coming in for treatment?

1) _____

2) _____

3) _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications/supplements: _____

_____

List serious illnesses, accidents or surgeries: _____

_____

_____

Check symptoms you have or have had in the last year:

___ Depression
___ Dizziness
___ Excessive worry
___ Excessive fear
___ Headaches
___ Loss or gain of weight
___ Feel overwhelmed by life
___ Difficulty focusing
___ Easily startled
___ Excessive anger
___ Fatigue/tiredness
___ Loss of sleep/poor sleep
___ Nervousness/irritability

Check conditions you have or have had in the past:

___ AIDS
___ Anemia
___ Bleeding disorders
___ Cancer
___ Allergies
___ Arthritis
___ Breast lump
___ Diabetes

Check illnesses that have occurred in blood relatives:

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

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

Health History (cont'd)

Check symptoms you have or have hadin the past year:

MUSCLES/JOINTS/BONES
___ Tremors or cramps
___ Swollen joints
Pain, weakness, or numbness in:
___ Arms or hips
___ Back or legs
___ 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 eaily
___ Dry skin
___ Itching/rash
___ Sensitive skin
___ Sores that don't heal
___ Sweats

GENITOURINARY
___ 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 nkles

GASTROINTESTINAL
___ Abdominal distension
___ Belching, gas or 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
___ Irregular cycle
___ Menopausal symptoms
___ PMS
___ Previous miscarriage/abortion
___ Scant menstrual flow
Could you be pregnant? _____

For men:
___ Erectile dysfunction
___ Discharge from penis
___ Prostate trouble

SIGNATURE

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

Signature: _____ Date: _____