

C E N T E R O F



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Health History

Name: _____

Today's date: _____

Address: _____

Birth date: _____

Age: ____ Sex: ____ Height: ____ Weight: ____

Work phone: _____ Home phone: _____ Local phone (if from out of town): _____

Marital Status: Single Married Divorced Separated Widowed

Living situation: _____

If under 18, parents name/address: _____ Education (yrs. completed): _____

Elem ____ HS ____ Coll ____ Voc ____ Prof ____

Occupation: _____

Retired: Yes No

Social Security #: _____

Emergency contact: _____

Phone #: _____

Relationship: _____

Referred by: _____

Address: _____

Family Physician: _____

Address: _____

*passion * authenticity * presence*

FAMILY HISTORY

Check if family history is unknown.

Age If dead, cause of death _____

Father _____

Mother _____

Siblings _____

Children _____

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

RELATIONSHIP

- Alcohol/drug problem _____
- Allergy/asthma _____
- Anemia _____
- Arteriosclerosis _____
- Arthritis _____
- Binge eating/bulimia _____
- Bleeding problem _____
- Cancer _____
- Diabetes _____
- Epilepsy/seizure _____
- Heart disease _____
- Skin disease _____
- Gonorrhea _____

RELATIONSHIP

- High blood pressure _____
- High cholesterol/fat _____
- Kidney disease _____
- Liver disease _____
- Mental illness _____
- Obesity _____
- Stroke _____
- Suicide _____
- Thyroid disease _____
- Tuberculosis _____
- Ulcer _____
- Syphilis _____

PAST HISTORY OF ILLNESS AND HEALTH PROBLEMS

Surgery: List all surgery and approximate dates Other hospitalizations and dates

Broken bones and/or traumatic injuries Current Health Problems

Include all car accidents or concussions Example: High Blood Pressure - 10 yrs

PAST HISTORY

	WHEN		WHEN		WHEN
<input type="checkbox"/> Acne _____		<input type="checkbox"/> Epilepsy _____		<input type="checkbox"/> Frequent nightmares _____	
<input type="checkbox"/> AIDS _____		<input type="checkbox"/> Epstein Barr _____		<input type="checkbox"/> Overweight (20 lbs) _____	
<input type="checkbox"/> Alcohol/drug prob. _____		<input type="checkbox"/> Fibrocystic breasts _____		<input type="checkbox"/> Panic attacks _____	
<input type="checkbox"/> Allergies _____		<input type="checkbox"/> Fibroids _____		<input type="checkbox"/> Pelvic infection _____	
<input type="checkbox"/> Amalgams/silver filings _____		<input type="checkbox"/> Gallbladder prob. _____		<input type="checkbox"/> Peptic ulcer _____	
<input type="checkbox"/> Anemia _____		<input type="checkbox"/> Glasses/contacts _____		<input type="checkbox"/> Periodontal disease _____	
<input type="checkbox"/> Antibiotics more than once a year _____				<input type="checkbox"/> Glaucoma _____	
<input type="checkbox"/> Phlebitis _____		<input type="checkbox"/> Anorexia _____		<input type="checkbox"/> Gout _____	
<input type="checkbox"/> Pneumonia _____		<input type="checkbox"/> Anxiety _____		<input type="checkbox"/> Hay fever _____	
<input type="checkbox"/> Premenstrual tension _____		<input type="checkbox"/> Arteriosclerosis _____		<input type="checkbox"/> Hearing problem _____	
<input type="checkbox"/> Prostrate problem _____		<input type="checkbox"/> Arthritis _____		<input type="checkbox"/> Heart attack _____	
<input type="checkbox"/> Psychotherapy _____		<input type="checkbox"/> Asthma _____		<input type="checkbox"/> Heart failure _____	
<input type="checkbox"/> Reaction to vaccinations _____		<input type="checkbox"/> Back pain/strain _____		<input type="checkbox"/> Heart problem _____	
<input type="checkbox"/> Rheumatic fever _____		<input type="checkbox"/> Binge eating _____		<input type="checkbox"/> Hemorrhoids _____	
<input type="checkbox"/> Root canal _____		<input type="checkbox"/> Bladder infection _____		<input type="checkbox"/> Hepatitis _____	
<input type="checkbox"/> Scarlet fever _____		<input type="checkbox"/> Blood clots _____		<input type="checkbox"/> Herpes _____	
<input type="checkbox"/> Sexually transmitted disease _____				<input type="checkbox"/> Breast fed _____	
<input type="checkbox"/> Hiatal Hernia _____		<input type="checkbox"/> Sinusitis _____		<input type="checkbox"/> Breast lump _____	
<input type="checkbox"/> High blood pressure _____		<input type="checkbox"/> Skin problem _____		<input type="checkbox"/> Bronchitis _____	
<input type="checkbox"/> High cholesterol / triglycerides _____				<input type="checkbox"/> Sleep disorder _____	
<input type="checkbox"/> Bulimia (self-induced vomiting) _____		<input type="checkbox"/> Cancer _____		<input type="checkbox"/> Histoplasmosis _____	
<input type="checkbox"/> Stroke _____		<input type="checkbox"/> Cataract _____		<input type="checkbox"/> Hives _____	
<input type="checkbox"/> Suicide attempt _____		<input type="checkbox"/> Chemical sensitivity _____		<input type="checkbox"/> Hypoglycemia _____	
<input type="checkbox"/> Syphilis _____		<input type="checkbox"/> Thyroid problem _____		<input type="checkbox"/> Infectious mono. _____	
<input type="checkbox"/> Taken steroid (cortisone/prednisone) _____		<input type="checkbox"/> Tonsillitis _____		<input type="checkbox"/> Chicken pox _____	
<input type="checkbox"/> Insomnia _____		<input type="checkbox"/> Tooth problems _____		<input type="checkbox"/> Chronic fatigue _____	
<input type="checkbox"/> Kidney infection _____		<input type="checkbox"/> Tuberculosis _____		<input type="checkbox"/> Coccidiomycosis _____	
<input type="checkbox"/> Kidney stones _____		<input type="checkbox"/> Urine problem _____		<input type="checkbox"/> Colds, frequent _____	
<input type="checkbox"/> Kidney problem _____		<input type="checkbox"/> Vaginitis _____		<input type="checkbox"/> Colitis _____	
<input type="checkbox"/> Liver disease _____		<input type="checkbox"/> Vision problem _____		<input type="checkbox"/> Congenital defect _____	
<input type="checkbox"/> Measles _____		<input type="checkbox"/> Warts _____		<input type="checkbox"/> Counseling _____	
<input type="checkbox"/> Menstrual problem _____		<input type="checkbox"/> Other problems _____		<input type="checkbox"/> Depression _____	
<input type="checkbox"/> Mental illness _____		<input type="checkbox"/> Eczema _____		<input type="checkbox"/> Diabetes _____	
<input type="checkbox"/> Migraine _____		<input type="checkbox"/> Neurological problem _____		<input type="checkbox"/> Ear infection _____	
<input type="checkbox"/> Mumps _____				<input type="checkbox"/> Nervous condition _____	
<input type="checkbox"/> Endometriosis _____					

PERSONAL HISTORY

Current medications Vitamin and mineral supplements
(list all prescriptions and non-prescriptions) (type and dosage)

Allergies

I am allergic to the following medications: Food Allergies: Method of testing:

Lifestyle

List your favorite foods or cravings:

I often eat seconds. yes no

To control my weight, I have used:

- fasting longer than 1 day
- self-induced vomiting
- enemas
- diuretics (water pills)
- other _____
- diet pills
- laxatives
- health/diet
- exercise

I am now or have been a smoker. yes no

How many years have you smoked? _____

When did you quit? _____

What do you smoke now? _____

How much? _____

I usually eat white bread commercial wheat bread

whole grain bread

I usually eat fresh frozen canned vegetables

I usually eat my vegetables raw steamed boiled

sautéed

I usually eat fruits: fresh frozen canned

I estimate my use of:

coffee: _____ cups/day

decaf: _____ cups/day

tea: _____ cups/day

soda: _____ cans/day

I use beer wine "hard" liquor
I consider myself a non-drinker social drinker heavy drinker alcoholic recovering alcoholic
I use marijuana other drugs _____ more than 3x/week less than 3x/week never
I think I need counseling or medical care to help me control use of alcohol tobacco food drugs
I eat beef or pork at least once a day 5x/week
I usually prepare my meat and fish pan fried deep fried baked broiled
I eat refined sugar yes no
My salt use is none added light moderate heavy
I drink city well spring distilled water _____ glasses a day.
I have participated in an exercise program. yes no
I exercise on a regular basis. yes no
I think this is enough exercise. yes no
I would like to do more exercise yes no
I sleep well. yes no
I worry about money job family life relationships other _____
_____ times per week month
I currently see a psychotherapist or other mental health professional. yes no
I find my work too demanding boring satisfactory very satisfying
I have had a therapeutic massage. yes no
I currently see a chiropractor, osteopath, or other person who'r tqxkf gu'r j { ulecl'vj gtr { 0
My sex life is satisfactory. yes no yes no
I have been arrested. yes no
I have been in the military service. yes no
I do the following for relaxation/recreation:

I have been the victim of physical sexual emotional abuse.
My spiritual life is satisfactory. yes no
I am currently involved in a regular spiritual program yes no
My last physical exam was _____.

LIFE CHANGES

In the past 12 months, what changes have occurred in your:

1. Personal Life

2. Family Life

3. Social Life

4. Work Life

5. Sex Life

REVIEW OF SYSTEMS

Answer "yes" if you have had these symptoms in the last 6 months

- | | | |
|---|---|--|
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Bad teeth |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Chronic depression | <input type="checkbox"/> Change in voice | <input type="checkbox"/> Coating on tongue |
| <input type="checkbox"/> Trembling episodes | <input type="checkbox"/> Dental problem | <input type="checkbox"/> Pain relieved by eating |
| <input type="checkbox"/> Light-headedness | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Food craving | <input type="checkbox"/> Excessive salivation | <input type="checkbox"/> Trouble with fried foods |
| <input type="checkbox"/> Frequent infection | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Bloating of abdomen |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Mouth breather | <input type="checkbox"/> Bowel gas |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Bloody/yellow sputum | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chills/fever | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Black stool |
| <input type="checkbox"/> Change in skin/nails | <input type="checkbox"/> with exertion | <input type="checkbox"/> Clay-colored stool |
| <input type="checkbox"/> Change in wart or mole | <input type="checkbox"/> at night | <input type="checkbox"/> Mucus in stool |
| <input type="checkbox"/> Abnormal bleeding/bruising | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Unusual hair loss/growth | <input type="checkbox"/> Chest pain with breathing | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> at rest | <input type="checkbox"/> Change in diet |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> with exertion | <input type="checkbox"/> Pain/burning during urination |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> with stress | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Balance problem | <input type="checkbox"/> with eating | <input type="checkbox"/> Urination at night |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> down left arm, neck or | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Seizure/convulsion | back | <input type="checkbox"/> Foul odor to urine |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> accompanied by nausea, | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Difficulty concentrating | sweating, anxiety | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Irregular heartbeat | MEN |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Skip beats | <input type="checkbox"/> Enlarged prostate |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Decreased urine stream |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Unable to interrupt stream |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Loss of any vision | <input type="checkbox"/> Swelling feet/legs | <input type="checkbox"/> Pus or drainage from penis |
| <input type="checkbox"/> Halos around lights | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Genital swelling/rash |
| <input type="checkbox"/> Excessive tearing/itching | <input type="checkbox"/> Leg cramps at night | <input type="checkbox"/> Problem with sexual function |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Pain or fatigue in legs with | |
| <input type="checkbox"/> Dark circles under eyes | exercise | |
| <input type="checkbox"/> Date last eye exam _____ | <input type="checkbox"/> Burning feet | |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Sore legs/feet | |
| <input type="checkbox"/> Ringing/buzzing in ears | <input type="checkbox"/> Color change of legs/arms | |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Difficulty swallowing | |
| <input type="checkbox"/> Nosebleed | <input type="checkbox"/> Pain/discomfort when eating | |

WOMEN

- Last menstrual period: _____
- Age began menstruation: _____
- Age at menopause: _____
- Number of pregnancies: _____
- Number of live births: _____
- Number of abortions/
miscarriages: _____
- Complication of pregnancy
- Used birth control pills
- Used IUD type: _____
- Usual length of cycle: _____
- Usual length of period: _____
- Change in cycle
- Spotting between periods
- Discomfort with periods
- Premenstrual tension
- Vaginal discharge
- Painful intercourse
- Itching
- Self-breast examination
- Self-vaginal examination
- Problem w/sexual function
- Lump in breast
- Abnormal pap smear
- Infertility
- Date of last pap smear: _____

Muscle pain Location: _____

Muscle weakness Location: _____

Joint pain Location: _____

Joint pain aggravated by motion

Joint pain relieved by motion

Swollen joints

Stiff joints

How do you feel when you wake up in the morning? _____

How often do you ordinarily eat (anything) during a 24-hour period? _____

Please add anything that you want us to know that has not already been covered.

Thank you for your participation. The practitioner will go over this questionnaire with you and help you develop an appropriate plan for further evaluation.

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