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email: wellness@naturalroute.org
phone: (847) 888-3131

Health History Form

Name:_____ Date:_____Date of Birth:_____

Street Address:_____
City:_____ State:_____ Zip:_____
Phone number: _____

Highest level of education:_____

Occupation:_____Employer_____
Work hours work per week:_____

Marital Status (circle):Single Married Separated Divorced With Partner Widow(er)

Person to call in case of Emergency:_____Relationship to you:_____
Phone number contact for them:_____

Primary care Physician:_____

List in Order of Importance your Health Goals:
1.
2.
3.
4.
What service(s) are you interested in:_____

List in Order of Importance your Health Concerns/Symptoms:
1.
2.
3.
4.
Last date of blood work:_____

What is your greatest health concern?_____
How does it limit you the most? _____

How committed are you towards making valuable changes:
Little Moderately Very

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Family History

Please indicate if any of the below health conditions have been diagnosed for you or your family members including your spouse, children, father, mother, siblings or grandparents.

Cancer (type)
High Blood Pressure
Stroke
Heart disease
Asthma/Allergies
Mental Illness/Depression
Gum Disease
Autoimmune disease
Diabetes Mellitus
Arthritis
Infections
Substance abuse

Death: please indicate if any of your family members listed above have died, their age and the cause of death. _____

List All Surgeries and Hospitalizations—including date occurred:

Motor Vehicle Accidents:_____

Please List All Sensitivities/Allergies/Reactions
Drugs: _____
Foods: _____
Environment: _____
List any vaccination reactions:_____

List all prescription medicines and nutrient supplement/herbs you are CURRENTLY Taking:

List any prescription medications or over the counter medications or ointments you have used in the PAST.

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Lifestyle Questionnaire

Please Circle Y if you have the problem **currently**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.

Exercise:
How often per week:_____
What type(s):_____
For How long:_____

Hobbies: _____

Food:
Appetite Good?: Y N P
Foods you crave: _____
Foods you are averse to: _____
Foods that don't sit well:_____

Social Life:
Enjoy job?: Y N P
Active Spiritual practice: Y N P
Quality of most significant relationship?_____
History of sexual, mental/emotional, physical abuse?: Y N
If so, at what age and by whom?: _____

Sleep:
How long per night: _____
If you wake up frequently, what is the reason: _____

Nightmares	Y N P	Sleep walk	Y N P
Must nap during day	Y N P	Grind teeth	Y N P
Wake refreshed	Y N P	Snore	Y N P

Antacids	Y N P	Alcohol (if yes, how often and how much)	Y N P
Smoking (if yes - packs per day)	Y N P	Any alcohol addiction/treatment	Y N P
Pain medications	Y N P	Recreational drugs	Y N P
Coffee (if yes, how many ounces per day)	Y N P	Any drugs addiction	Y N P
Soda Pop (if yes, how many ounces per day)	Y N P	Any drug treatment	Y N P
Laxatives	Y N P	Steroid Use/Rash Creams	Y N P

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Review Of Systems

Please Circle Y if you have the problem **currently**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.

General			
Present weight		Height	
Ideal weight		Blood pressure (last dr's visit)	
Tired	Y N P	Time of day with lowest energy	
Energy	Y N P	1-10 (10 being highest)	
Skin			
Rash	Y N P	Color Change	Y N P
Hives	Y N P	Lump	Y N P
Psoriasis/eczema	Y N P	Warts/moles	Y N P
Dry	Y N P	Perspiration	Y N P
Cancer	Y N P	Itchy	Y N P
Head			
Headache	Y N P	Migraine	Y N P
Dandruff	Y N P	Head Injury	Y N P
Oily/dry hair	Y N P	Hair loss	Y N P
Nose			
Frequent colds	Y N P	Nosebleeds	Y N P
Congestion	Y N P	Postnasal drip	Y N P
Polyps	Y N P	Seasonal allergies	Y N P
Eyes			
Dry/Watery	Y N P	Blurry vision	Y N P
Double vision	Y N P	Cataracts	Y N P
Glaucoma	Y N P	Discharge	Y N P
Strain	Y N P	Styes	Y N P
Mouth/Throat			
Canker sores	Y N P	Cold sores	Y N P
Sore throat	Y N P	Gum disease	Y N P
Dentures	Y N P	Cavities	Y N P
Loss of taste	Y N P	Hoarseness	Y N P

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Neck			
Stiffness	Y N P	Swollen glands	Y N P
Full movement	Y N P	Tension	Y N P
Dentures	Y N P	Cavities	Y N P
Loss of taste	Y N P	Hoarseness	Y N P
Respiratory			
Cough	Y N P	Covid-19	Y N P
Shortness of breath with exertion	Y N P	Bronchitis	Y N P
Shortness of breath sitting	Y N P	Pneumonia	Y N P
Shortness of breath lying down	Y N P	Asthma	Y N P
Wheezing	Y N P	Painful breathing	Y N P
Cardiovascular			
High blood pressure	Y N P	Rheumatic Fever	Y N P
Low blood pressure	Y N P	Murmurs	Y N P
Irregular heart beat	Y N P	Palpitations	Y N P
Edema	Y N P	Chest pain	Y N P
Gastrointestinal			
Heartburn	Y N P	Change in Appetite	Y N P
Indigestion	Y N P	Ulcer	Y N P
Bloating	Y N P	Pancreatitis	Y N P
Nausea	Y N P	Hemorrhoids	Y N P
Vomiting	Y N P	Liver disease	Y N P
Burping/Gas	Y N P	Gall bladder disease	Y N P
Diarrhea or constipation	Y N P	Recent change in stools	Y N P

Bowel Movement Description: circle all that apply

Number of times a day:
Shape: log like, ball like, sand like, mud like
Color: brown, gray, black, green, red
Appearance: normal, mucous, bubbles, food, blood
Smell: none, some foul smell, very foul smelling
Strain: no straining, some straining, very difficult

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Female			
Age periods began		Heavy Bleeding	Y N P
Number of days periods last		Cramping	Y N P
Food Cravings around period		Pain	Y N P
Number of days in between periods		Mood changes	Y N P
Menopausal since what age		Fatigue/bloating	Y N P
Number of times Pregnant		Abortions/Miscarraiges	Y N P
How many live births		Sexually Active	Y N P
Date of last Pap Smear		Healthy Libido	Y N P
Any abnormal paps		Pain With Intercourse	Y N P
Birth Control (please list types and ages used)		Dry Vagina	Y N P
Dexa Scan		Vaginitis	Y N P
Use of Hormones		Sexually Transmitted Diseases (list)	Y N P
Sexual Orientation	Hetero /Homo/ Bi	Mammography	Y N P
Male			
Pain with urination	Y N P	Prostate disease/symptoms	Y N P
Kidney stones	Y N P	Testicular pain/swelling	Y N P
Discharge/blood	Y N P	Hernia	Y N P
Frequent infections	Y N P	Sexually active	Y N P
Frequency/Urgency	Y N P	Sexually transmitted disease	Y N P
Incontinence	Y N P	Impotency	Y N P
Sexual orientation	Hetero /Homo/ Bi		

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Urinary Tract			
Incontinence	Y N P	Pain with urination	Y N P
Frequent infections	Y N P	Kidney stones	Y N P
Urgency	Y N P	Discharge/blood	Y N P
Musculoskeletal			
Back pain	Y N P	Leg cramps	Y N P
Arthritis	Y N P	Muscle twitching	Y N P
Tingling/Numbness	Y N P	Sciatica	Y N P
Carpal tunnel syndrome	Y N P		
Mental/Emotional			
Depression	Y N P	Anger/Irritability	Y N P
Suicidal	Y N P	High strung/tense	Y N P
Anxiety	Y N P	Fear/Panic	Y N P

Toxin Exposure

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_____

Are you particularly sensitive to perfumes, gasoline, or other vapors?:_____

Do you use pesticides, herbicides, other chemicals around your home?_____