

SANDHILLS CHINESE HERBAL SCIENCE

HEALTH HISTORY FORM

Full name _____ Today's date _____

Mailing address _____

City _____ State _____ Zip _____

Street address, if different _____

City _____ State _____ Zip _____

Home phone (include area code) _____ Business/Work Phone _____

Age _____ Date of birth _____ Sex _____ Marital Status _____

Occupation _____ Religious affiliation, if any _____

I was referred by _____

Reason for referral _____

Nearest friend or relative _____

Mailing address _____

City _____ State _____ Zip _____

Give the following information about your immediate family's health:

Relationship	Age, if living	Age at death	State of health or cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers & Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Have any of your blood relatives had any of the illnesses listed below? If so, indicate relationship (father, sister, etc.)

<u>Illness</u>	<u>Family Member(s)</u>	<u>Illness</u>	<u>Family Member(s)</u>
Asthma	_____	Glaucoma	_____
Tuberculosis	_____	Rheumatoid Arthritis	_____
High Blood Pressure	_____	Gout	_____
Heart Disease	_____	Rheumatic Fever	_____
Stroke	_____	Epilepsy	_____
Diabetes	_____	Mental Disorder	_____
Cancer	_____	Alcoholism	_____
Blood Disease	_____		

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List all surgery, hospitalization and serious Injuries you have had:

<u>Year</u>	<u>Surgery, Illness or Injury</u>	<u>Hospital and City</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of the following illnesses and disorders you have or have had and indicate the approximate year when each

	(X)	Year		(X)	Year
eye or eyelid infection	_____	_____	stomach or duodenal ulcer	_____	_____
glaucoma	_____	_____	colitis	_____	_____
other eye problems	_____	_____	diverticulosis	_____	_____
	_____	_____	other bowel problem	_____	_____
ringing in the ears	_____	_____	hemorrhoids	_____	_____
deafness or poor hearing	_____	_____	hepatitis	_____	_____
other ear problems	_____	_____	other liver problems	_____	_____
	_____	_____	gall bladder problems	_____	_____
headaches	_____	_____		_____	_____
head injury	_____	_____	hemia	_____	_____
stroke	_____	_____	kidney or bladder problems	_____	_____
convulsions or seizures	_____	_____	prostate problems	_____	_____
	_____	_____		_____	_____
allergies, asthma, hay fever	_____	_____	arthritis	_____	_____
strep throat	_____	_____	gout	_____	_____
bronchitis	_____	_____	cancer or tumor	_____	_____
pneumonia	_____	_____	bleeding tendency	_____	_____
tuberculosis	_____	_____		_____	_____
emphysema	_____	_____	measles/rubeola	_____	_____
other lung problems	_____	_____	German measles/rubella	_____	_____
	_____	_____	scarlet fever	_____	_____
high blood pressure	_____	_____	chicken pox	_____	_____
heart attack	_____	_____	mumps	_____	_____
heart murmur	_____	_____		_____	_____
high cholesterol	_____	_____	polio	_____	_____
arteriosclerosis	_____	_____	mononucleosis	_____	_____
other heart condition	_____	_____	eczema	_____	_____
	_____	_____	psoriasis	_____	_____
thyroid disorder	_____	_____	venereal disease	_____	_____
diabetes	_____	_____		_____	_____
	_____	_____	Other.....	_____	_____
	_____	_____	Please explain: _____	_____	_____

List the current challenges which are of the most concern to you.

<u>Date Began</u>	<u>Challenge</u>
_____	_____
_____	_____
_____	_____

List any disorders for which you are being treated by another health care practitioner.

<u>Illness or disorder</u>	<u>Practitioner's name</u>	<u>City</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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List all medications you are now taking, Including non-prescription drugs and nutritional supplements.

List Items to which you are allergic (e.g., foods, medications, penicillin, bee stings, pollens, dust, chemicals, soaps, etc.), and Indicate how each Item affects you.

Fill In the years In which you had the following Inoculations:	Have you traveled in a foreign country in the last 20 years? No Yes	
Tetanus _____ measles _____ mumps _____	<u>Country traveled in</u>	<u>Date(s)</u>
polio _____ typhoid _____ influenza _____	_____	_____
Other _____	_____	_____

Have you had a tuberculin (TB) skin test? No _____ Yes _____

If so, the date of test was _____ and the result was:

Negative	Positive
<u>No</u>	<u>Yes</u>

Have you ever worked or spent time.....on a farm ?

in a laundry or mill?	_____	_____
in a very dusty place?	_____	_____
in a mine?	_____	_____
with or near toxic chemicals?	_____	_____
with or near radioactive chemicals?	_____	_____
with or near asbestos?	_____	_____

Have you recently had any changes in your: (If yes; please explain on line to left.)

	<u>No</u>	<u>Yes</u>
_____ marital status?	_____	_____
_____ job or work?	_____	_____
_____ financial status?	_____	_____
_____ residence?	_____	_____
_____ Are you having any legal problems?	_____	_____

What is your present weight? _____ lb

What is your present height now? _____ ft _____ in

Presently, how is your general health?..... Good _____ Fair _____ Poor _____

How has your health been most of your life? Good _____ Fair _____ Poor _____

In the past year:.....has your appetite changed? Stayed the same _____ Increased _____

Decreased _____

has your weight changed? No change _____ Gained _____ lb

Lost _____ lb

are you often noticeably thirsty? No _____ Yes _____

your general energy level changed? Stayed the same _____ Increased _____

Decreased _____

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	<u>Rarely/Never</u>	<u>Sometimes</u>	<u>Often</u>
Do you:become tired easily?	_____	_____	_____
feel depressed?	_____	_____	_____
feel bored most of the time?	_____	_____	_____
have trouble making decisions?	_____	_____	_____
worry a lot?	_____	_____	_____
feel nervous?	_____	_____	_____
have trouble relaxing?	_____	_____	_____
become angry easily?	_____	_____	_____
have sexual problems?	_____	_____	_____
ever feel like committing suicide?	_____	_____	_____
use marijuana?	_____	_____	_____
use hard drugs?	_____	_____	_____

	<u>No</u>	<u>Yes</u>
.....Do you often feel tired easily?	_____	_____
Have you ever fainted or felt like fainting?	_____	_____
Do you get cold hands or feet easily?	_____	_____
Do you sweat easily?	_____	_____
Do you often have difficulty sleeping?	_____	_____
, Do you often sleep restlessly?	_____	_____
Does any part of your body get numb?	_____	_____
Do you ever have fits or convulsions?	_____	_____
Do you ever shake or tremble?	_____	_____
Do you ever have any problem with coordination?	_____	_____

In the last 3 months have you had:a fever lasting more than a day?	_____	_____
any cold sores (fever blisters)?	_____	_____
sores or cuts that were hard to heal?	_____	_____
any lumps in your neck, armpit or groin?	_____	_____
chills or sweating at night?	_____	_____

Do you have:dry skin?	_____	_____
brittle fingernails?	_____	_____
any moles that have changed in color or in size?	_____	_____
any other skin problems?	_____	_____
Do you bruise easily?	_____	_____

	<u>Rarely/Never</u>	<u>Sometimes</u>	<u>Often</u>
In the past year have you had:feelings of nervousness?	_____	_____	_____
shoulder pain?	_____	_____	_____
back pain?	_____	_____	_____
muscle or joint stiffness or pain due to sports, exercise or injury?	_____	_____	_____
pain or swelling in any joints not due to sports, exercise or injury?	_____	_____	_____

.....Do you wear eyeglasses?	_____	_____
Do you wear contact lenses?	_____	_____
Has your vision changed in the last year?	Yes	No

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In the past year:

How often do you have.....double vision?
 blurry vision ?
 watery or itchy eyes?

Do you:.....ever see colored rings around lights?
 have difficulty hearing?
 ever have ringing in your ears?
 ever feel dizzy or experience motion sickness?
 become angry easily?
 have trouble keeping your balance?
 have any discharge from your ears?

How often do you have:.....headaches?
 neck pains?

Rarely/Never Sometimes Often

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have problems with your:.....teeth?
 gums, jaw, or roof of mouth?
 tongue or taste sense?

No Yes

_____	_____
_____	_____
_____	_____

How often do you have.....head colds?
 chest colds?
 runny nose?
 stuffed up nose?
 sneezing spells?
 nose bleeds?
 sore or hoarse throat?
 coughing spells?
 trouble breathing?
 coughing up of blood?
 earaches?

Rarely/Never Sometimes Often

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

.....Do you get short of breath when physical-ly active?
 Do you sometimes feel light headed or dizzy?
 Have you ever fainted or passed out?
 Does your heart ever feel like it is racing or beating too fast?
 When you exercise do you get pains in your chest or shoulders?
 Do you have cramps or pain in your thighs or legs when walking?
 Do you need to sit up at night to breathe more easily?
 Do you use several pillows at night to help you breathe more easily?
 Do your legs cramp up at night?
 Do you have swollen ankles or feet?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How often, if ever:.....are you nauseated?
 do you belch a lot after eating?
 do you have heartburn?
 do you have stomach pains?
 is it difficult for you to swallow your food?
 have you vomited blood?
 are you constipated?
 do you have diarrhea?
 Are your bowels movements painful?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Have you ever had a sigmoidoscopy?..... No _____ Yes _____

	<u>Rarely/Never</u>	<u>Sometimes</u>	<u>Often</u>
.....Do you have difficulty beginning to urinate? Is urination painful?	_____	_____	_____
Do you have to urinate more than [5 times if you are male,8 times if female] per day?	_____	_____	_____
Do you get up at night to urinate?	_____	_____	_____
Do you ever urinate while sleeping?	_____	_____	_____
Do you ever lose urine when you laugh, cough, sneeze, or strain hard?	_____	_____	_____
Has your urine ever been bloody or dark colored?	_____	_____	_____
Has your urine ever been cloudy or milky in appearance?	_____	_____	_____

MEN ONLY:

	<u>No</u>	<u>Yes</u>
.....Do you have prostate trouble?	_____	_____
Do you have any sexual problems or impotency?	_____	_____
Have you ever had sores or lesions on your penis?	_____	_____
Have you ever had discharge from your penis?	_____	_____
Do you ever have pain, lumps or swelling in your testicles?	_____	_____

WOMAN ONLY:

What is the typical number of days between your menstrual periods?

the minimum is _____ days; the maximum is _____ days

	<u>Rarely/Never</u>	<u>Sometimes</u>	<u>Often</u>
Are they accompanied by:..... ..pain and cramping?	_____	_____	_____
nausea?	_____	_____	_____
heavy bleeding or menstrual flow lasting longer than 4 days ?	_____	_____	_____
depression or irritability?	_____	_____	_____
Do you experience:.....swelling and edema prior to menstruating?	_____	_____	_____
bleeding between periods?	_____	_____	_____
pain on intercourse or sexual activity?	_____	_____	_____
vaginal irritation or discharge?	_____	_____	_____
Do you ever have:.....breast sensitivity?	_____	_____	_____

Do you receive regular breast exams from your physician?..... Yes _____ No _____

Date of : last gynecological exam _____ last pap smear _____

Name of gynecologist _____

	<u>Start Date(s)</u>	<u>End Date(s)</u>	<u>Age(s)</u>
List dates and ages when you have used birth control pills or an IUD:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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How much do you exercise? All I need _____ Less than I need _____ Little or none _____

What specific types of exercise or sports do you do, and how much per week?

Do you smoke now?..... No _____ Yes _____

If yes, how many years? _____

How many each day? _____ cigarettes _____ cigars _____ pipe-fulls

Have you ever smoked? No _____ Yes _____

If yes, how many years? _____

How many each day? _____ cigarettes _____ cigars _____ pipe-fulls

Do you drink alcoholic beverages? No _____ Yes _____

Per day, I drink

_____ 12 oz cans of beer _____ 8 oz glasses of wine _____ oz of hard liquor (vodka, etc)

Have you ever had a problem with alcohol? No _____ Yes _____

Do you drink coffee or tea (do not include herbal teas that do not contain significant levels of caffeine)? No _____ Yes _____

Per day, I drink _____ 8 oz cups

NUTRITION and DIET

How many meals do you eat each day? _____ meals

Do you usually eat breakfast? No _____ Yes _____

Do you diet frequently? No _____ Yes _____

Are you dieting now? No _____ Yes _____

Do you, in reference to your weight, consider yourself: Just right _____ Overweight _____
Underweight _____

Do you snack? Rarely _____ Dailey _____
More than once per day _____

Do you add salt to your food at the table? Rarely _____ Sometimes _____
Frequently _____

Check the frequency where which you eat the following foods: more than once daily daily 3 times weekly once weekly Rarely or never

whole grain cereal or bread	_____	_____	_____	_____	_____
other starches (pasta, white bread, etc.)	_____	_____	_____	_____	_____
sugar, desserts	_____	_____	_____	_____	_____
dairy products	_____	_____	_____	_____	_____
eggs	_____	_____	_____	_____	_____
fresh meat, poultry, fish	_____	_____	_____	_____	_____
smoked or processed meat	_____	_____	_____	_____	_____
beans, peas	_____	_____	_____	_____	_____
nuts and seeds	_____	_____	_____	_____	_____
citrus fruit or juice	_____	_____	_____	_____	_____
other fruit or juice	_____	_____	_____	_____	_____
dark green, deep yellow.....	_____	_____	_____	_____	_____
& orange vegetables	_____	_____	_____	_____	_____
other vegetables	_____	_____	_____	_____	_____
vinegar, pickled foods	_____	_____	_____	_____	_____

Additional challenges you wish to discuss:

Client's signature: _____

Clinician's comments:

After you complete this form please bring it to your first appointment or return it before your first appointment to:

**SANDHILLS CHINESE
HERBAL SCIENCE**

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