Comprehensive Health History

Welcome and Congratulations, YOU ARE HERE and have taken the first step!

Please do your best to fill out this questionnaire. It is helpful for me to know your history including past and current stressors so that I can address the goals you have for care.

Name (legal)____________________________________Legal Gender* Female Male

*While TLC recognizes a number of genders / sexes, many insurance companies unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your name and pronouns are different from these, please let us know.

Name____ **Pronouns**___________________________

Address____
Street City State Zip Code

Best Phone # for you: _________________________ **Email** _____________________________________

Date of Birth: __________________ **Relationship status**_____________________________________

Children, Name(s) & Age(s): ____

Emergency Contact: ____________________________________**Relationship to you:** _____________

Occupation:____________________________**Avocation**_______________________________________

About Your Health

The human body is designed to be healthy. Our Nervous System is self-organizing and wired for survival and relationship. When we are threatened or overwhelmed the wisdom of our body protects us until such a time as healing is possible. NOW IS THAT TIME! This Health History will help me understand the layers of stored experiences in your body.

Current Health Concern

What is the reason for your visit today?

____

____

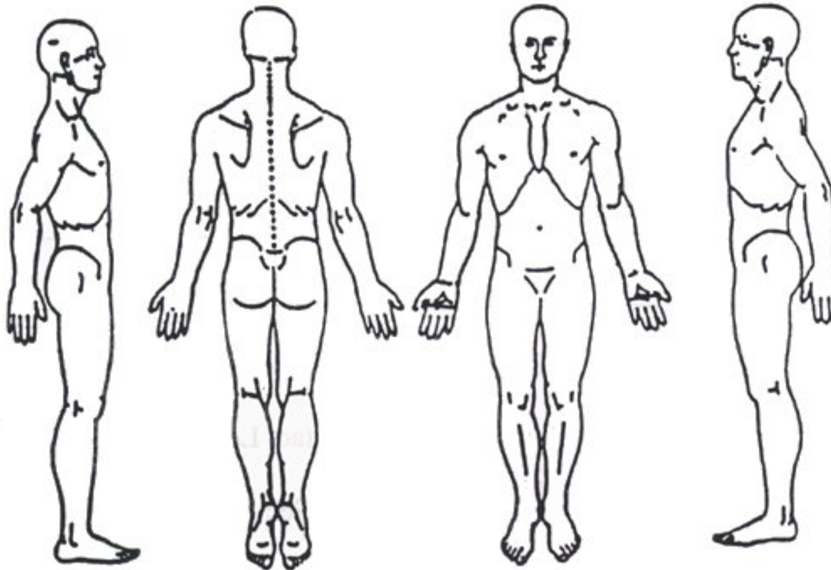
When did you first notice this? ____

What would your life be like if this were not there?____

____

What are your Goals for Care?____

Mark on this picture any areas of concern.



Circle any words that apply:
Do you have: Pain------Numbness------Tingling-----Other ____________________________

How would you describe the sensation?
Dull-------Ache------Sharp------Dull------ Burning-----Throbbing-----Constant-----Intermittent
____

Is there anything that makes your condition/pain better? Y N
Explain: ____

Is there anything that makes your condition/pain worse? Y N
Explain: ____

Circle the # that best describes the intensity**:**
(low) 0 1 2 3 4 5 6 7 8 9 10 (high)

Have you seen any other health professional or received any advice or treatment for this?
Y N Explain: ____

What do you think is going on?____

Have you done anything for this (Including but not limited to ice, heat, rest, massage, diet change, drugs) ____

Is this getting worse, better, or staying the same?
Explain: ____

Does this affect any of the following?(circle all that apply)

Mood/attitude/patience-------relationships & intimacy------activity & play------work-------
day-to-day activities------ability to relax------overall quality of life
Are there any other health concerns that are important to you?________________________________
____

Developmental History (pre-birth thru age 18)

Your MOM's Pregnancy with YOU: ***Check all that apply***
Tobacco____ Alcohol____ Medications_____ Recreational Drugs____ Falls/Injuries_____
Abuse (Physical, sexual or emotional?)____ Positive memories of being a child?________
*Details of any checked?*____
____

Your Birth: ***check all that apply***
____Hospital ____Home ____ Vaginal ____ Cesarean(Emergency or scheduled)
____Forceps ____Vacuum/Suction ____Induced ____ Epidural ____Complications
*Details of any Checked?*____
____

Your Childhood (0-18): ***Check all that apply***
____ Breast fed ____ Significant events ____ Vaccinations (all or modified?)
____Falls/accidents/injuries ____Fractures/Dislocations ____Ear Infections ____ Colic
____Asthma ____Surgeries/Hospitalizations _____Special Diet ____Allergies
____Crawled before Walking ____ Abuse(physical, sexual, or emotional?) ____ MVA's
*Details of any checked:*____
____

Adult History: Age 18 to present *Check all that apply*

Please mark any of the following conditions or symptoms that you have now or have experienced:
Mark all that apply with (N) for Now, (P) for Past

___ Weight changes
___ Frequent Colds/Flu
___ Fever
___ Asthma/Respiratory
___Hormone Therapy
___ Sinus/Allergies
___ Skin Conditions
___ Neck/Back pain
___ High cholesterol
___ High blood pressure
___ Heart Attack
___ Stroke
___ Depression
___ Organ removal

___ Psychiatric
___ ADHD/ADD
___ SAD
___ Concussion/Head
___ Digestive problems
___ Cancer
___ Menstrual problems
___ Reproductive
___ Numbness/Tingling
___ Dental/Jaw issues
___ Headaches
___ Diabetes
___ Arthritis
___ Bowel/bladder changes

___ Painful Urination
___ Urinary Tract
___ Diarrhea/Constipation
___ Dizziness/Vertigo
___ Ear/Hearing Issues
___ Eye/Vision Issues
___ Thyroid Disorder
___ Shortness of Breath
___ Nervousness/Anxiety
___ Ringing in Ears
___Motor Vehicle Accident
___PTSD
___Trauma

*Other:*____

Mark all that apply:
___Tobacco ___Alcohol ___Medications ___Recreational drugs ___Vaccinations
___Falls/injuries ___Accidents ___Surgeries/organs removed ___Dislocations/fractures ___Sports injuries ___Abuse (Physical, sexual, or emotional)

Other Stressors that have impacted your life, now or in the past:

____

____

___*Particular diet (type:_____________)* ___ *Vitamins or supplements (details:_______________)*
___*Regular exercise* _______________________ */type?*___________________________________*)*
___*Occupational stress* ___*Mental/emotional stress* ___*Physical stress* ___*Chemical stress*
*Details of any checked:*____

____

Sleep habits: ___ *Hours per night /* ___*Sound or* ___*Disrupted /* ___ *Nightmares /*
___ *Sleep apnea /* ___ *Snoring*
Details of any checked: ____

Female Born: *Please fill out the following questions regarding your own pregnancies/births.*
Miscarriage or Abortions: Y N Please explain:____
Are you taking birth control? Y N
Pregnancy & Birth Story:

____

____

____

Current Pregnancy: Due date ___________________
Do you plan on delivering at: Home Birthing Center Hospital
If not delivering at home, please name birthing location: _________________________________
Do you plan on using a: Midwife Doula Nurse Midwife OB
Names:____
Do you plan on breastfeeding? Yes No
For how long? ______________________________ or why not? ___________________________
Do you plan on vaccinating? Yes No

For those who have had surgery please indicate type and your age at the time. __________________

____

Have you served in the military or law enforcement?____

What brings you peace, joy and/or happiness?____

Signature ____ Date ___________________________

Remember, health is a process and a way of living. Past and present choices affect this process. Thank you for taking the time to provide me with the information I need to best help you achieve your health goals.