Bridge to Higher Health
717-737-7224

Health History Questionnaire

Full name at birth
(include any current additions; e.g. married or spiritual name)

Today's Date Birth Place

Birth Date Birth Time

Sex: Male Female

Height Weight

Street Address

City State Zip

( ) ( )
Home Phone Cell Phone

( ) ( )
Work phone Fax number

Email Address:

Who referred you to us?

Please list known diagnoses and or diseases:

Please list your personal health goals:

Courses of antibiotics taken in your lifetime:
Less than 5 *5 -10* *More than 10*

Please check all that apply:

I have been diagnosed with heart disease.
I have a family history of heart disease.
I wear a pacemaker

For Females Only:

Are you currently pregnant?
Are you currently nursing?
Are you currently on progesterone/estrogen therapy?
Number of abortions:
Are you currently using birth control?
What type?

Suppression and Obstruction to Health Index

Number of organs removed:
(Including teeth)
Number of synthetic drugs used currently:
Amount of smoking per day:
(Include cigarettes, cigars, etc.)
Number of steroid type drugs used in the last year:
Number of mercury amalgam fillings present/ any metal:
Number of street drugs used monthly:
(Include recreational street drugs)
Number of known allergies:
(foods, skin, and inhalants)
Number of unresolved mental factors:
(stuck or unresolved emotions)
I am taking responsibility for my body:
(0 – minimum 10 – maximum)
Amount of fat in diet: %
Current Personal Stress:
(0 – minimum 10 – maximum)
Number of sugar type products or processed foods per day:
Number of exercise sessions per week:
(Minimum. of 20 minutes with HR above 100 BPM)
Number of alcoholic drinks per day:
Number of cups of coffee or caffeine per day:
(include caffeinated tea and chocolate)
Number of extreme toxic exposures per year:
(Radiation, Pesticides, Insecticides, etc.)
Number of major injuries in the past:
(include physical and emotional traumas)
Number of major infections in the past:
Number of 8oz glasses of water or natural fruit juice per day:
How many pounds overweight (as seen by client):

Orthopedic History

Please check all past injured regions, including surgeries-type and date. Explain.

Head Thoracic spine
Neck (cervical) Lumbar spine
TMJ Hips R/L
Shoulders R/L Pelvis
Elbows R/L Knees R/L
Hands R/L Ankles R/L
Wrists R/L Feet R/L
Other