Energy Matters, LLC

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Health History Form

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask at your visit.

Name:_____Date: _____

Address:
_____

City _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email address: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Occupation: _____ Phone: _____

Physician: _____ Phone: _____

In Case of Emergency, please notify: _____ Phone: _____

Describe what brings you here and what outcome you desire _____

Describe your treatment to date _____

Body Surgeries/Scars: (Please list dates)_____

_____

Dental Surgeries: (implants, root canals, veneers, dentures, bridges, pulled teeth). (Please list dates)

_____

Significant Trauma (physical, emotional) _____

Allergies (chemical, environmental, food, drugs, etc.)_____
_____

Medications/Vitamins/Supplements/Herbs _____

_____

Exercise: Days per Week: _____ Length of Workout(s): _____

Type of Exercise: _____

Typical Diet: Breakfast _____ Lunch_____

Dinner _____ Snacks _____

Caffeinated Beverages (what/how many) _____ Alcohol beverages (per week) _____

Do you smoke cigarettes? _____ Marijuana? _____ Other? _____

Are you a vegetarian? _____ Do you eat artificial sugars?_____

Personal History: **Please CIRCLE any conditions or symptoms you have/have had. Provide the date below each item, if known.**

Arthritis	Liver/Gall Bladder	Stroke	Heart Disease
High/Low Blood Pressure	Hypo/Hyperglycemia	Kidney Disease	High Cholesterol
Cancer	Diabetes	Food Allergies/Intolerance	IBS/Diverticulitis
Ulcer	Seizures	Hepatitis	Raynaud's Disease
Chronic Fatigue	Anemia	Thyroid Imbalance	Respiratory Allergies
Alcoholism	Lyme Disease	Chronic Pain	Impotence
Gastritis/Pancreatitis	Asthma	Infertility	Emphysema
Other:			

Family Medical History: **Please CIRCLE any condition that applies to you or your immediate family. Please provide the date below each item, if known**.

Diabetes	Seizures	Cancer

High blood pressure	Allergies	Stroke
Heart Disease	Asthma	Other:

Please CIRCLE any condition that you have had in the last 3 months. Provide the date below.

General Symptoms:

Poor Appetite	Poor sleep	Fatigue	Fever
Overeating	Dental/gum problems	Sweat easily	Night sweats
Bodily heaviness	Poor balance	Cold hands/feet	Weight loss/gain
Peculiar tastes/smells	Tremors	Sudden energy drop	Change in appetite
Bleed/bruise easily	Muscle weakness/fatigue	Other:	

Mouth

Dental Implants	Root canals	Caps/Veneers	Dentures/Bridges
Pulled Teeth	Gum problems	Grinding teeth	Injury to Teeth
Bad Breath	Other:		

Skin and Hair

Rashes	Ulcerations	Hives/Allergic Dermatitis	Itching
Eczema/Psoriasis	Dandruff	Loss of hair	Recent moles
Skin discoloration	Acne	Warts	Face flushing
Dermatitis	Fungal Infections	Body Odor	Dandruff
Bruise easily	Athlete's Foot	Growths	Cysts

Ulcerations	Other:		

Head, Eyes, Ears, Nose and Throat

Eye Strain	Ringing in Ears	Headaches	Facial Pain
Eye Pain	Poor Hearing	Difficulty swallowing	Jaw Clicks/Locks/TMJ
Color blindness	Earaches	Nose Bleeds	Dizziness
Cataracts	Recurrent sore throat	Migraines	Poor Vision
Sinus Problems	Hearing Loss	Concussion	Blurred Vision
Wear Contacts/Glass	Other:		

Cardiovascular

Chest pain/pressure	High blood pressure	Low blood pressure	Irregular heart beat
Swelling of hands/feet	Varicose/spider veins	Shortness of breath	Palpitations at rest
Dizziness	Fainting	Blood clots	Leg cramps
Phlebitis	Heart murmur	Other:	

Respiratory

Cough/Wheezing	Asthma	Pneumonia	Bronchitis
Coughing blood	Pain with inhalation	Tight sensation in chest	Production of phlegm
Other:			

Gastrointestinal

Nausea	Vomiting	Diarrhea	Constipation
Gas	Black Stools	Blood in stools	Mucous in stool
Indigestion	Loose stools	Rectal pain	Bloating/edema
Hernia	Stomach ulcer	Changes in appetite	Abdominal pain/cramps
Hemorrhoids	Significant thirst	Acid reflex/GERD	IBS/Crohn's Disease
Changes in appetite	Chronic laxative use	Rectal bleeding	Eating disorder
Appendectomy	Other:		

Genito-Urinary

Pain on urination	Frequent urination	Blood in urine	Impotence
Unable to hold urine	Kidney stones	Scanty urine flow	Infections
Urgent urination	Genital sores	Prostatitis	Urinary tract infection
Burning urination	Decreased libido	Herpes	Pain in testicles
Erectile dysfunction	Other:		

Gynecological/Reproductive

Difficult/Painful intercourse	Endometriosis	Date of last period:
Vaginal Dryness	Uterine fibroids	Date of last PAP/ Pelvic exam:
Vaginal sores	Fibrocystic breast tissue	Number of pregnancies:
Vaginal discharge	Polycystic Ovarian Syndrome	Number of live births:
Infertility	PMS	Number of miscarriages:
Irregular Menstruation	Painful menstruation	Number of abortions:

Do you practice Birth Control: Y/N	Ovarian cysts	Age of first menses:
What type:		
How long:	Menopause difficulties	Other:

Musculoskeletal

Neck pain	Knee pain	Limited range of motion	Bursitis
Shoulder pain	Hand/wrist pain	Sprains/strains	Carpal tunnel
Hip pain	Foot/ankle pain	Muscle pain	Tendonitis
Back pain	Muscle weakness	Sciatica	Rotator cuff
Breaks/fractures	Numbness	Tingling	Leg Cramps
Difficulty Walking	Other:		

Neuropsychological

Seizures	Nervousness	Bad temper/irritable	ADD/ADHD
Lack of Coordination	Depression	Considered/attempted suicide	Easily stressed
Anxiety/panic attacks	Seasonal Affective Disorder	Seeing a therapist	Poor memory
Crying spells	Confusion	Phobias/Fears	Other:

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Finger Analysis

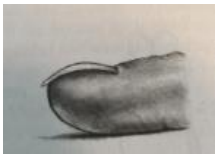
Please circle the image(s) that best matches the appearance of your fingernails.

Round Nail

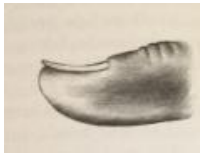
Square Nail

Triangle Nail

Striped Nail



Rounded Nail



Spoon Nail

Bump on Nail

Groove on Nail

Use a finger to press on one of your nails as shown in the image below. How long does it take for the color to return? _____ seconds

Please list any other problem/concerns you would like to discuss.