# Integrative Medical Clinic
## Personal Health Survey

Name:_____Age_____

Please complete this Personal Health Survey. All practitioners at IMC will have access to this information and it will be entered electronically into your clinic record. Add pertinent information at the end of any section.

1. A brief history of your major health concern(s)

2. Your top health priority:

**MEDICAL HISTORY**

3. Medical Problems/issues (ck those that apply) Name of Doctor seen for this problem/when

☐Diabetes _____/_____
☐High Blood Pressure _____/_____
☐Cancer:_____ _____/_____
☐Arthritis: Joint:_____ _____/_____
☐Heart Disease:_____ _____/_____
☐Asthma,lung prob:_____ _____/_____
☐Chronic Problem:_____ _____/_____
☐Other(s)_____ _____/_____

4. **Allergies** to medications, foods, animals etc:

5. Women's History: Age of menarche (starting your periods)_____
Still having periods: ☐ No ☐ Yes
Regular? ☐No ☐Yes: Every ____days Extra heavy flow: ☐No ☐Yes
PMS Symptoms? ☐No ☐ Yes:_____

Pregnancies _____ Deliveries____ Miscarriages____ Abortions____
Any problems with your pregnancies or deliveries?

6. **Medications/Herbs/Supplements** Dose/mgs/etc How many times a day

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

☐(please check box if additional page included with medications)

7. Have you been the victim of any abuse -physical, emotional, sexual ☐no ☐yes
Please give brief history:

Have you ever had counseling regarding this abuse? ☐no ☐ yes

8. Surgery History Dates Hospital/Town

☐ Tonsils
☐ Appendix
☐ Gallbladder
☐ Hysterectomy
☐ Ovaries
☐ Colon
☐ Cancer: Type:
☐ OTHER:

9. Injury History

| Where was the injury | When was the injury | How did it happen |
|---|---|---|
| ☐ Back_____ | _____ | _____ |
| ☐ Neck_____ | _____ | _____ |
| ☐ Knee_____ | _____ | _____ |
| ☐ Arms/shoulders_____ | _____ | _____ |
| ☐ Other_____ | _____ | _____ |

**SOCIAL/WORK/HABITS**

10. Alcohol : ☐ Never drink
☐ I think, or someone else thinks, I have a problem with alcohol
Number of drinks/glasses of wine a week_____

11. Tobacco ☐ Never used
☐ Quit _____ years ago: Smoked ___packs/day for____years

12. Drugs: Have you ever used recreational drugs: ☐ No ☐ Yes:
When:_____
Have you stopped? ☐ yes ☐ no, how much do you use:_____

13. Safety: Do you wear your seat belt regularly: ☐ No ☐ Yes
Do you have a working fire alarm in your home: ☐ No ☐ Yes
Do you have guns in the home: ☐ No
☐ Yes: Are guns separate from bullets: ☐ Yes ☐ No

**FAMILY HISTORY**-

14. Have any of your immediate family members had these conditions, and what relation?
☐ Diabetes
☐ Heart Attack: how old?:
☐ Cancer: ☐ Breast ☐ Ovarian ☐ Colon. ☐ Melanoma
Other:
☐ Stroke:
☐ Tuberculosis:
☐ Abuse:
☐ Other:

**NUTRITION/EXERCISE/STRESS/SLEEP**
15. How many glass of water do you drink a day:

What is your sleep pattern? When do you go to sleep? How long do you sleep? Do you feel rested when you wake? Do you do anything to help your sleep?

16.– Please record a THREE DAY DIET LIST – Everything you ate for three days
(Please use a separate piece of paper and include with this survey.)

Breakfast: Usual time:
What do you usually have:

Lunch: Usual time:
What do you usually have:

Dinner: Usual time:
What do you usually have:

Snacks; Usual times:
What do you usually have:

**EXERCISE**
17. What is your usual exercise pattern each week?

**STRESS MANAGEMENT**
18. What is your current stress level– 1 (mild) - 10 (extreme):
What are causes/examples of your major stresses:

How do you handle your stress, and what do you DO to manage your stress?

**SPIRITUALITY/ RELIGION**
19. Do you have a regular spiritual/religious practice? If so, what is it?

How does your practice impact your healing?

**YOUR HEALING**
20. What factors most aid or hinder your health and healing?

21. What have you deliberately changed at some time in your life? How did you do that? How did you reward yourself for that change?

22. What habits or aspects of your health would you like to change?

What have you done to begin that change process (check all that apply):
☐ Thought about it ☐ Planned what I would do ☐ Started doing it
☐ Stopped for a while ☐ Restarted again
Comments:

**Modalities History**

| Modality – used for: | Used | Helpful | Interested in trying |
|---|---|---|---|
| Acupuncture | ☐ | ☐ | ☐ |
| Biofeedback | ☐ | ☐ | ☐ |
| Chiropractic | ☐ | ☐ | ☐ |
| Body Work:type: | ☐ | ☐ | ☐ |
| Massage | ☐ | ☐ | ☐ |
| Psychotherapy | ☐ | ☐ | ☐ |
| Nutrition | ☐ | ☐ | ☐ |
| Naturopathic Med | ☐ | ☐ | ☐ |
| Energy work:type | ☐ | ☐ | ☐ |

**SYMPTOM REVIEW** – Please note any problems or symptoms you have in the following:

Eyes, Ears, Nose or Throat: Ringing in ears?

Headaches?

Respiratory : Cough, Wheezing, Shortness of Breath?

Heart: Chest pain, irregular heart rate??

Digestive: Constipation, Diarrhea, Bloating, Black stool or blood in stool?

Skin :

Urination problems?

Neurologic: numbness or tingling in hands or feet? Unsteadiness? Dizziness?

Emotional / Psychological concerns? Do you feel sad? Do you feel depressed?

**What else should we know about your health?**