PATIENT HEALTH APPRAISAL

Alternative Health Care of Western Massachusetts
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PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY

IMPORTANT*: The information requested in this form is of vital importance in determining the care and correction of your health problem. Please write neatly and be as accurate as possible.*

Read each question carefully and score only those statements which pertain to you.

If a question does not apply to you, leave it blank. If you are not sure and have a doubt about a question, or wish to clarify the answer, describe in the space available.

Name ____ Age __________ today's Date _____________________
Address ________________________________ City _________________ State ________ Zip __________________
Phone (Home) ________________Date of Birth __________Sex: M F Marital Status: S M D W #Children______
Email Address: __________________________________
Occupation __________________________Employer _______________________Phone (Work) ________________
Emergency Contact ________________________Phone Number __________________
Referred By _____________________________
***YOUR MAJOR REASON FOR SEEING THE DOCTOR:** ____

___

Have you ever been treated for this problem? ☐ NO ☐ YES
If yes, by ☐ Physician (M.D) ☐ Chiropractic Physician (D.C) ☐ Physical Therapist ☐ Osteopath ☐ Other
What did they do/ recommend? ____
When did your symptoms appear? ________ Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown ☐
Is it constant or does it come and go?____
Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation?
Activities which are difficult to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Other_____________

CONDITIONS Check conditions you have or have had in the past.

☐ Aids
☐ Anemia
☐ Alcoholism/Addiction
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Auto Immune Diseases
☐ Bleeding disorders
☐ Breast lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical dependency
☐ Chicken pox
☐ Diabetes
☐ Epilepsy
☐ Emphysema
☐ Fractures
☐ G.E.R.D
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart disease
☐ Hepatitis A B or C
☐ Hernia
☐ Herpes
☐ High Cholesterol
☐ High Blood pressure
☐ HIV Positive
☐ Kidney disease
☐ Liver Disease
☐ Measles
☐ Migraine headaches
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Prosthesis
☐ Psychiatric care
☐ Rheumatoid arthritis
☐ Rheumatic Fever
☐ Scarlet fever
☐ Stroke
☐ Suicide attempt
☐ Thyroid problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors, growths
☐ Typhoid fever
☐ Ulcers
☐ Vaginal infections
☐ Venereal disease
☐ Whooping Cough
☐ Other

MEDICATIONS: List any medications you are currently taking **VITAMINS/HERBS/MINERALS**

___

Allergies____
Pharmacy Name ____Phone ______________________

PLEASE INDICATE ANY DIETARY RESTRICTIONS:______________________________________

____

OPERATIONS AND PROCEDURES

Date		Date		Date	
	Vaccinations		Tubes in Ears		Sinus
	Tonsillectomy		Appendectomy		Hernia
	Gall Bladder		Female Organs		Thyroid
	Back operation		Rectal Surgery		Stomach
	Other		Other		Other

☐ I have never had any operations / surgeries.

Your doctor is interested in helping you in the following areas of your health naturally and without side effects:
SCORE THE SEVERITY OF SYMPTOMS WHICH APPLY TO YOU FROM 1 TO 5. Leave others Blank.

1. Very Mild or Occasional
2. Mild
3. Moderate
4. Severe
5. Very Severe

GENERAL *DESCRIBE*

001 ☐ Are you overweight or underweight? ______________________________

002 ☐ Do you exercise? ______________________________

003 ☐ Do you smoke? ______________________________

004 ☐ Do you drink alcoholic beverages daily? ______________________________

005 ☐ Do you use recreational drugs? ______________________________

006 ☐ Do you have hypertension? ______________________________

007 ☐ Do you drink less than 6 glasses of water daily? ______________________________

008 ☐ Sexual problems? ______________________________

009 ☐ Are you often dizzy? ______________________________

010 ☐ Do you experience spells of rapid heart beat? ______________________________

011 ☐ Are you aware of your heart skipping beats? ______________________________

012 ☐ Blood pressure problems? ______________________________

013 ☐ Circulatory problems? ______________________________

014 ☐ Do you have cold hands or feet? ______________________________

015 ☐ Do you have varicose veins? ______________________________

016 ☐ Do you have excessive thirst? ______________________________

017 ☐ Do you frequently feel hot? ______________________________

018 ☐ Are you unusually tired most of the time? ______________________________

019 ☐ Are you unusually jumpy or nervous? ______________________________

020 ☐ Do you have epilepsy? ______________________________

021 ☐ Do you suffer from motion sickness? ______________________________

022 ☐ Eye condition? ______________________________

023 ☐ Other ______________________________

SKIN

024 ☐ Teenage acne? ____________________
025 ☐ Middle age acne? ____________________
026 ☐ General unhealthy skin? ____________________
027 ☐ Oily, dry, or itchy skin? ____________________
029 ☐ Eczema – Psoriasis or cracking skin? ____________________
030 ☐ Cysts, warts, moles, liver spots, fungal growths? ____________________
031 ☐ Rashes, vesicles? ____________________
032 ☐ Herpes or Shingles? ____________________
033 ☐ Are you troubled with boils? ____________________
034 ☐ Do you get sore that are slow to heal? ____________________
035 ☐ Do you bruise easily? ____________________
036 ☐ Other ____________________

IMMUNE

037 ☐ Food allergies? ____________________
038 ☐ Sensitivity to chemicals? ____________________
039 ☐ Hay fever? ____________________
040 ☐ Asthma? ____________________
041 ☐ Emphysema? ____________________
042 ☐ Frequent colds or flu? ____________________
043 ☐ Frequent sore throats? ____________________
044 ☐ Are your glands often swollen? ____________________
045 ☐ Frequent laryngitis? ____________________
046 ☐ Frequent cough? ____________________
047 ☐ Do you have a chronic chest condition? ____________________
048 ☐ Do you have post nasal drip? ____________________
049 ☐ Frequent sinusitis? ____________________
050 ☐ Is your nose frequently stuffy? ____________________
051 ☐ Do you spit up phlegm? ____________________
052 ☐ Frequent earaches or discharges? ____________________
053 ☐ Hair or nail problems? ____________________
054 ☐ Weakness or exhaustion? ____________________
055 ☐ Eating relieves fatigue? ____________________
056 ☐ Feel shaky when hungry? ____________________
057 ☐ Poor concentration? ____________________
058 ☐ Crave sweets or stimulants? ____________________
059 ☐ Loss of memory? ____________________
060 ☐ Confusion? ____________________
061 ☐ Other? ____________________

DIGESTION/ ENDOCRINE

062 ☐ Do you have stomach ulcers? ____________________
063 ☐ Do you have liver or gall bladder disease? ____________________
064 ☐ Are you diabetic? ____________________
065 ☐ Do you get lightheaded when standing quickly? ____________________

066 ☐ Do you have excessive hunger? ______
067 ☐ Do you eat when nervous? ______
068 ☐ Do you have black, tarry or bloody stools? ______
069 ☐ Constipation? ______
070 ☐ Do you use laxatives? ______
071 ☐ Diarrhea or colitis? ______
072 ☐ Indigestion, gas or bloat? (When) ______
073 ☐ Heartburn? ______
074 ☐ Hemorrhoids, fissures, polyps? ______
075 ☐ Have you even had intestinal worms, itchy nose or rectum? ______
076 ☐ Gout? ______
077 ☐ Are you frequently nauseated? ______
078 ☐ Have you been diagnosed with a thyroid condition? ______
079 ☐ Are you on any hormone replacement? ______
080 ☐ Other ______

NEUROMUSCULOSKELETAL

081 ☐ Do you have rheumatoid arthritis? ______
082 ☐ Does any part of the body experience numbness, tingling? ______
083 ☐ Back problems? ______
084 ☐ Spinal curvature? ______
085 ☐ Do you suffer from muscle spasms? ______
086 ☐ Are you muscles frequently sore? ______
087 ☐ Do you have muscle weakness? ______
088 ☐ Are your joints stiff in the morning? ______
089 ☐ Do you suffer from painful feet? ______
090 ☐ Do you have plantar warts? ______
091 ☐ Do you have heel spurs? ______
092 ☐ Are you troubled with corns? ______
093 ☐ Sciatica? ______
094 ☐ Headaches, sinus, or migraine? ______
095 ☐ Sports injuries? ______
096 ☐ Jaw problems? ______
097 ☐ Tremors or neurological disease? ______
098 ☐ Other ______

MEN

099 ☐ Prostrate, dribbling after urination? ______
100 ☐ Impotency, decreased sexual desire? ______
101 ☐ Other ______

WOMEN

102 ☐ Are you pregnant? ______
103 ☐ Do you take birth control pills? ______
104 ☐ Do you have pre-menstrual depression? ______
105 ☐ Is intercourse painful for you? ______

106 ☐ Do you have diminished sexual drive? ____________________
107 ☐ Have you had a hysterectomy? ____________________
108 ☐ Do you retain fluid during your period? ____________________
109 ☐ Do you have frequent yeast infections? ____________________
110 ☐ Problems with fertility? ____________________
111 ☐ Problems with miscarriage? ____________________
112 ☐ Morning sickness? ____________________
113 ☐ Menopause? ____________________
114 ☐ Premenstrual sickness? ____________________
115 ☐ Dysmenorrhea? ____________________
116 ☐ Feminine discharge? ____________________
117 ☐ Breast cysts, lumps, or mastitis? ____________________
118 ☐ Excessive appetites? ____________________
119 ☐ Desire to vomit after eating? ____________________
120 ☐ Obsessive dietary habits? ____________________
121 ☐ Other ____________________

URINARY

122 ☐ Do you have frequent urination? ____________________
123 ☐ Are you a bed wetter? ____________________
124 ☐ Have you lost control of your bladder, or dribble when sneezing or laughing? ____________________
125 ☐ Do you have painful urination? ____________________
126 ☐ Do you have frequent kidney or bladder infections? ____________________
127 ☐ Do you have kidney stones? ____________________

CHILDREN

128 ☐ Bedwetting? ____________________
129 ☐ Colic? ____________________
130 ☐ Swollen tonsils? ____________________
131 ☐ Learning disabilities? ____________________
132 ☐ Hyperactivity? ____________________
133 ☐ Teething problems? ____________________
134 ☐ Other ____________________

BEHAVIORAL

135 ☐ Nervousness? ____________________
136 ☐ Agoraphobia: fear of crowds or going out of the house? ____________________
137 ☐ Claustrophobia: Fear of closed spaces? ____________________
138 ☐ Depression? ____________________
139 ☐ Manic depression or severe personality shifts? ____________________
140 ☐ Any severe mental or emotional traumas? ____________________
141 ☐ Grief or guilt? ____________________
142 ☐ Insomnia? ____________________
143 ☐ Do you feel you are under considerable emotional stress? ____________________
144 ☐ Do you have any obsessive behavior of any type? ____________________
145 ☐ Other ____________________

List all forms of physical traumas, chemical exposures, mental stress as pertaining to your employment, home lifestyle, etc.:

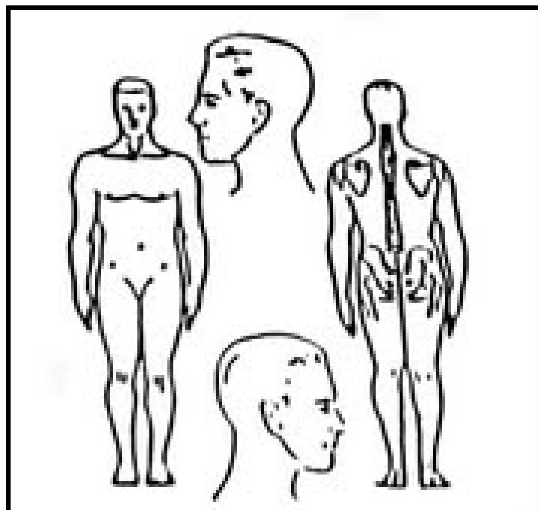
List all nutritional supplements, home remedies, etc. your have tried and their results. List what you are currently taking.

Confidential information: Please feel free to write any information that you feel is individually important to your health and well being. This information is necessary for us to provide you with the highest quality care possible.

The major health problems of your immediate family will assist us in understanding your health pattern. Report all diseases, sicknesses, reasons for hospitalization, cause and age of death, etc.

Name	Relation	Health Problems

Please Mark your areas of pain on the figures below:



The information I have provided is to the best of my knowledge, accurate and true.

Date: ____

Signature/ Signature of parent or guardian ____