In Tune Healing Arts
Jenny Kaltunas ND, LAC
9500 Roosevelt Way NE, Suite 301, Seattle, WA 98115

Health History Questionnaire

Date: _____

Name: _____ Age: _____ Sex: M F Transgender

Address: _____ / _____ / _____ / _____
Street #/PO Box *City* *State* *Zip Code*

Telephone: (H) _____ (C) _____ (W) _____

Email: _____ Date of birth:_____

SS#:_____ Referred by: _____

Emergency Contact: _____Emergency Contact Phone #:_____

Occupation:_____

Most Recent Primary Care Information:
Physician's Name: _____ Phone: _____
Address: _____

HEALTH CONCERNS *List, in order of importance, your health concerns and how long you have had these concerns or condition(s):*

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

What do you believe is the **cause** of condition #1?_____

_____

Have you been given a **diagnosis** for any of these problems?_____

_____

What **treatment** have you tried (self or physician prescribed)?

_____

_____

How much does this problem interfere with your life (on a scale of 1 to 10, 10 is the worst) _____

List known **allergies** to either food or drugs: _____

_____

Current **medications**: _____

_____

_____

Current **supplements** or **over-the-counter items**: _____

_____

_____

When were you last seen by a physician? _____

List **lab work** completed:

_____

_____

Have you seen a Naturopathic Physician or Acupuncturist before? Please circle.

Please describe your **average daily diet**:

Morning:_____

Afternoon: _____

Evening: _____

Snacks: _____

Water intake: _____

Circle the items that you use. Indicate how much and how often.

Coffee _____

Tea_____

Alcohol _____

Recreational Drugs_____

Chocolate _____

Cigarettes _____

Sugar/Artificial Sweeteners _____

Describe any special **dietary restrictions:** _____

_____

Have you had any significant **accidents, injuries** or **illnesses**? _____

_____

_____

List any other **hospitalizations** or **surgeries** you have had, and your age at the time:

_____

_____

List any unusual childhood illnesses: _____

_____

FAMILY HISTORY: Check all conditions that have affected your parents, grandparents, siblings & children

CONDITION	Relatives/s Affected	CONDITION	Relatives/s Affected
Addiction(s)	_____	Genetic Disease	_____
Allergies	_____	Gout	_____
Arthritis	_____	Headache/Migraine	_____
Asthma	_____	Heart Disease	_____
Bladder/Kidney	_____	High Blood Pressure	_____
Bleeding Issues	_____	Lung Issues	_____
Cancer	_____	Overweight	_____
Depression	_____	Stroke	_____
Diabetes	_____	Thyroid Disease	_____
Digestive	_____	Intestinal Issues	_____
Suicidal/Suicide	_____	Other Mental Illness	_____

PREVENTATIVE CARE HISTORY:

Exams	Last Completed Physical _____	Results: _____	By whom? _____
	Hemocult (blood in stool) _____	Results: _____	By whom? _____
	Last Sigmoidoscopy of colon _____	Results: _____	By whom? _____
Females	Last Mammogram _____	Pregnant Y N	
	Last Pap Smear _____	Results: _____	Breast Self-Exam Y N
	Last Breast Exam _____	Results: _____	
Males	Last Prostate Exam _____	Results: _____	Prostatitis Y N Urinary Freq. Y N
Children	Learning Issues Y N	Poor Attention Span Y N	Hyperactivity Y N

LIFESTYLE:

ACTIVITY LEVEL:

__Sedentary (inactive) by choice

__Sedentary (inactive) due to inability or restriction

__Light: light daily work w/no regular exercise

__Moderate: light daily work and exercise 3X/week

__Sustained: moderate daily work & exercise 5X/week

__Sustained: moderate daily work & exercise 5X/week

STRESSES AFFECTING YOUR LIFE:

__Difficulties with work or lifestyle

__History of trauma

__Death or serious illness of family or friend

__Dysfunctional family __Past __Present

__Lack of love or fulfilling relationship(s)

__Illness - self

Spiritual Practice _____

Type of preferred activity/exercise/movement _____

_____

Comments (please mention any other problems you would like to discuss):

_____

_____

_____

Please check any you have had in the last three months:

General
_ Poor appetite
_ Fevers
_ Sweat easily
_ Localized weakness
_ Bleed or bruise easily
_ Sudden energy drop – what time of day? _____
_ Poor sleep
_ Chills
_ Tremors
_ Poor balance
_ Fatigue
_ Night sweats
_ Cravings
_ Change in appetite
_ Weight gain
_ Weight loss

Skin and Hair
_ Rashes
_ Itching
_ Dandruff
_ Change in hair or skin
_ Ulcerations
_ Eczema
_ Loss of Hair
_ Hives
_ Pimples
_ Recent moles
_ Other hair or skin problems

Head, Eyes, Ears, Nose, and Throat
_ Dizziness
_ Glasses
_ Poor vision
_ Cataracts
_ Ringing in ears
_ Sinus problems
_ Grinding teeth
_ Teeth problems
_ Concussions
_ Eye strain
_ Night blindness
_ Blurry vision
_ Poor hearing
_ Nose bleeds
_ Facial pain
_ Jaw clicks
_ Migraines
_ Eye pain
_ Color blindness
_ Earaches
_ Spots in front of eyes
_ Recurrent sore throats
_ Sores on lips or tongue
_ Headaches - where and when _____
_____
_ Other head or neck problems _____

Cardiovascular
_ High blood pressure
_ Irregular heartbeat
_ Cold hands or feet
_ Blood clots
_ Low blood pressure
_ Dizziness
_ Swelling of hands
_ Phlebitis
_ Chest pain
_ Fainting
_ Swelling of feet
_ Difficulty in breathing
_ Other heart or blood vessel problems _____

Respiratory
_ Cough
_ Bronchitis
_ Difficulty in breathing when lying down
_ Production of phlegm what color _____
_ Coughing blood
_ Pneumonia
_ Asthma
_ Pain with a deep breath
_ Other lung problems _____

Gastrointestinal
_ Nausea
_ Constipation
_ Black stools
_ Bad breath
_ Abdominal pain or cramps
_ Chronic laxative use
_ Vomiting
_ Gas
_ Blood in stools
_ Rectal pain
_ Diarrhea
_ Belching
_ Indigestion
_ Hemorrhoids
_ Other stomach or intestinal problems _____

Genito-urinary
_ Pain on urination
_ Urgency to urinate
_ Frequent urination
_ Unable to hold urine
_ Impotency
_ Blood in urine
_ Kidney stones
_ Sores on genitals
_ Other genital or urinary system problems _____

Do you wake up to urinate? Y N
How often?_____
Any particular color to your urine? _____

Pregnancy and Gynecology
Number of pregnancies ____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Days between menses _____
Duration _____
First day of last menses ____
Menopause Yes No
_ heavy or light periods
_ Painful periods
_ Vaginal discharge
_ Changes in body/psyche prior to menstruation
_ Clots
_ Vaginal sores
_ Irregular periods
_ Breast lumps
Do you practice birth control? Yes No
What type and for how long?
_____

Musculoskeletal
_ Neck pain
_ Back pain
_ Hand/wrist pain
_ Muscle weakness
_ Shoulder pain
_ Knee pain
_ Foot/ankle pain
_ Hip pain

Neuropsychological
_ Seizures
_ Areas of numbness
_ Concussion
_ Bad temper
_ Dizziness
_ Lack of coordination
_ Depression
_ Easily susceptible to stress
_ Loss of balance
_ Poor memory
_ Anxiety
_ Other neurological or psychological problems