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Confidential Health History & Lifestyle Assessment

PERSONAL INFORMATION **Date:** ____/____/_____

Name_____ Age_____ DOB____/___/____Email _____
Address_____ City_____ State____ Zip_____
Phone (Home) _____ (Work) _____ Daytime / Evening? _____
Occupation_____ (Full or Part Time?) Employer _____

INSURANCE INFORMATION

Subscriber Name_____ Health Plan/Ins Co. _____
Subscriber ID# _____ Group # _____ Spouse _____
Spouse Employer _____City _____ State _____ Zip _____

Who can we reach in case of emergency:
Name _____ _____ Phone _____ Relationship _____

Whom can we thank for referring you to our office? _____
Primary Care Physician_____ PCP Phone _____
When was your last blood test? _____ Type of Test? _____

CURRENT HEALTH STATUS/CONDITION

What is your main reason for coming in today? Please tell us when and how it began. (PLEASE PRINT CAREFULLY)

Please list in order of importance other health problems that are troubling you:
1.) _____ & Length of time _____
2.) _____ & Length of time _____
3.) _____ & Length of time _____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist, nutritionist or other alternative health Practitioner for your current problem (Yes or no) or for any problem? (Yes or no).

What was the therapy and what were the results? _____
_____

HEALTH HISTORY

The **general** state of your health is: (Excellent ___) (Good ____) (Average_____) (Fair _____) (Poor _____)
Describe your energy level on average from 1 –10 (10 being highest): _____
What time of day is your energy the best? _____ Worst? _____
What is your current approximate weight? _____ Height? _____ Weight 1 yr ago? _____
As an adult, what has been your maximum weight? _____ Minimum_____

Have you had any spinal x-rays, MRI, CT Scan for your area (s) of complaint? YES / NO
Area of Study and Date: _____ Date: _____
Area of Study and Date: _____ Date: _____

On a scale of 1-10 / Where would you rate your level of daily stress? _____
Please list the 3 **most recent**, stressful events in your life, starting with the most recent. (Do not include pregnancy) Are any of these situations continuing to impact your life? (Yes or no) Please circle
1.) _____ Date _____
2.) _____ Date _____
3.) _____ Date _____

Please place a check by any of the childhood illnesses that you know you have had?
Measles _____ mumps_____ Chickenpox _____ Whooping cough_____
Polio _____ Diphtheria _____ Rheumatic fever _____ Scarlet fever _____
Small pox _____ Typhoid fever _____ tuberculosis _____ Mono _____(How long?) _____

Please check any condition below that you have experienced and the approximate year?

____ Pneumonia _____	____ Diabetes _____	____ Gonorrhea _____
____ Tonsillitis _____	____ Asthma _____	____ Syphilis _____
____ Ear Infections _____	____ Eczema _____	____ Venereal Disease _____
____ Chronic Infections _____	____ Heart Disease _____	____ Epilepsy _____
____ Canker Sores _____	____ Herpes _____	____ High Blood Pressure _____
____ Allergies _____	____ Hepatitis _____	____ Mononucleosis _____
____ Thyroid problems _____	____ Weight Problem _____	____ Anemia _____

____ Others _____

Do you have any allergies to any drugs, herbs, foods, animals or other? (Y or N)
If so, have you ever had a food sensitivity test (Y or N) When? ____/_____/_____

Which of the following do you currently use? (Please state the amount and frequency please.)
Alcohol _____ Tobacco_____
Soda _____ Coffee _____
Cortisone _____ Laxatives _____
Sedatives _____ Antacids _____
Other Medication (please give full name, dosage and how long you have been taking the medication)

1. _____ 2. _____
3. _____ 4. _____

Vitamins/ Herbs (please give full name, dosage and how long you have been taking them)

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

GENERAL FAMILY HEALTH HISTORY
Cancer _____ Cardiovascular Disease _____ Diabetes _____ High Blood Pressure ____ Stroke _____
Rheumatoid Arthritis _____ Osteoporosis _____ Back Problems _____ Migraines _____ Seizures _____

You currently live with? Spouse _____ Partner _____ Parents_____ Friends_____
Children_____Alone / Married_____ Separated_____ Divorced_____ Widowed_____
Single_____

De you have any children? _____ How many? _____ Toxemia during pregnancy? (Y or N)

Do they have any health problems? _____

Do you have any blood relatives (aunts, uncles, grandparents) who have had any of the following?

_____ Allergies	_____ Arthritis	_____ Asthma	_____ Cancer	_____Diabetes
_____ Anemia	_____ Depression	_____ Skin Disease	_____ Heart Attack	_____ High B.P.
_____ Stroke	_____ Ulcers	_____ Cataracts	_____ Thyroid Prob.	
_____ Hypoglycemia	_____ Seizures	_____Sickle Cells	_____ Venereal Disease	

Are there any congenital health problems that you are concerned about inheriting from your family?

GENERAL QUESTIONS

What do you enjoy most in your life? _____
Do you exercise? (Y or N) If yes what type & how often? _____
On a scale of 1-10, how would you rate the quality of your sleep? (10 being great) _____
Problems falling or staying asleep? (Y or N) How many hours do you sleep at night? _____
Do you sweat while sleeping? (Y or N) How frequently and how much do you sweat? _____ _____
Do you wake up feeling refreshed? (Y or N)
Do you feel your (hands or feet) are (warm, cool or average) temperature generally? (Circle)
Do you enjoy your work? (Y or N) Do you take vacations? (Y or N)
How often do you get colds, flu's, sore throat, or yeast infections during the year? _____
When you rise quickly form a sitting or lying position do you ever get dizzy? (Y or N)
- If yes, how often? (Daily, few times per week, 1xWeek, 2xMonth, 1xMonth, rarely)

OCCUPATIONAL / HOUSEHOLD

Do you have specialized air filtration at home? (Y or N)
Do you work in an office building? (Y or N) Do you have specialized air filtration at work? (Y or N)
Do you work in the presence of toxic fumes of chemicals? (Y or N)
Are you exposed to second hand smoke currently? (Y or N)

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if my insurance company denies payment for any claims or I am not eligible, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

I also understand that Dr. Xanthos may need to contact my primary physician if my condition needs to be co-managed. I give Dr. Xanthos permission to contact my physician and if necessary send them a copy of my record of care.

Patient Signature _____ Date: _____