Crossings Healing & Wellness

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Confidential 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 your answers are absolutely confidential. If you have any questions, please ask.

GENERAL INFORMATION

Name _____ Gender ☐F ☐M ☐Transgender Date _____

Address _____ City _____ State _____ Zip _____

Email _____Phone: ☐Home _____ ☐Cell/Work _____

Date of Birth _____ Age _____ Weight _____ Marital Status _____

Occupation_____ Hours/week _____ Length of time _____

Previous Occupation(s) _____ Where did you hear about us? _____

Emergency contact name & relation _____ Phone: _____

Name of physician _____ Phone _____

GENERAL HEALTH INFORMATION

On a scale of 1 (low) to 10 (high), how stressful is your: Work _____ Health status _____ Social/Family situation _____

Are you satisfied with your primary relationship and/or support system? ☐Yes ☐No

What are your primary health concerns and/or conditions (include duration, frequency, diagnoses & prior treatments)?

_____

_____

_____

_____

Does anything relieve these conditions? (Rest, movement, heat, cold, fresh air, eating, etc.)

_____

Does anything trigger, aggravate, or make your condition(s) worse? (Stress, fatigue, hunger, heat, cold, certain foods, damp days)

_____

LIFESTYLE INFORMATION – Do you use any of the following:

	Past/Present	How Long	Type	Frequency
Tobacco				
Alcohol				
Coffee/Tea				
Soft Drinks				
Recreational Drugs				

Do you Exercise? _____ Type(s) _____ How often? _____

MEDICAL HISTORY

Have you lived or traveled abroad for a significant length of time? Where/when? _____

Injuries & trauma(s) (Physical or emotional) _____

Surgeries (Please indicate dates of procedures) _____

_____

_____

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

Major events in the past 10 years & dates they occurred (births, deaths, marriages, divorce, accidents, major illness, surgery, job changes, miscarriages, & anything else that has greatly impacted your live and/or your health)

_____

_____

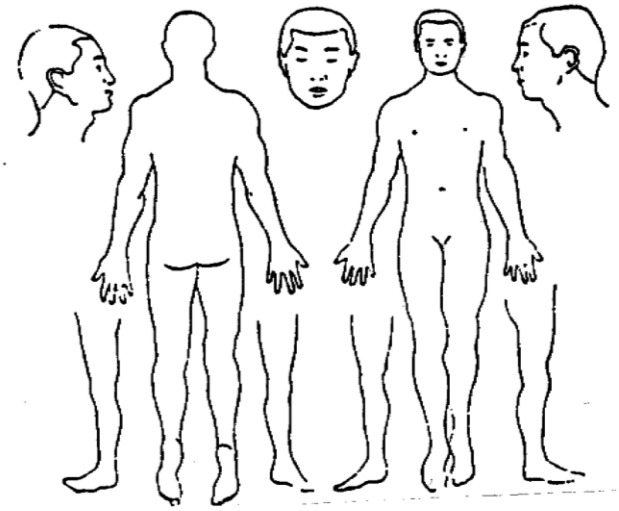
_____

_____

Medications – prescription, over the counter, recreational, herbal remedies, supplements

Name	Dosage/Frequency	Reason	How long?

Please mark all areas of pain/discomfort on the chart below:



FAMILY MEDICAL HISTORY – Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

☐Diabetes _____ ☐Seizures _____ ☐Heart Disease _____ ☐Stroke _____
☐High Blood Pressure _____ ☐Allergies _____ ☐Cancer _____ ☐Asthma _____
☐Other_____

PERSONAL HISTORY – Please check any conditions or symptoms that you currently have now.

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

Please check if you have had any of these items listed below in the last year. Put a star on the box if you had this in the past but do not any longer.

GENERAL HEALTH

- ☐ Poor Appetite
- ☐ Poor Sleeping
- ☐ Fatigue
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweats Easily
- ☐ Tremors
- ☐ Cravings
- ☐ Localized Weakness
- ☐ Poor Balance
- ☐ Change in appetite
- ☐ Bleed/Bruise easily
- ☐ Weight loss/gain
- ☐ Peculiar tastes/smells
- ☐ Dental/gum problems
- ☐ Muscle weakness/fatigue
- ☐ Sudden energy drop
- ☐ Strong thirst (hot or cold drinks)

SKIN & HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives/Allergic Dermatitis
- ☐ Itching
- ☐ Eczema/Psoriasis
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Recent moles
- ☐ Skin discoloration
- ☐ Acne
- ☐ Change in skin/hair texture
- ☐ Face flushing
- ☐ Dermatitis
- ☐ Warts
- ☐ Fungal Infection
- ☐ Weak or ridged nails

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Difficulty swallowing
- ☐ Migraines
- ☐ Glasses
- ☐ Eye Strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Spots in front of eyes
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Recurrent sore throats/colds
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Sores on lips/tongue
- ☐ Dental problems
- ☐ Jaw clicks/locks
- ☐ Headaches

CARDIOVASCULAR

- ☐ Chest pain or pressure
- ☐ Irregular heart beat
- ☐ Palpitations at rest
- ☐ Fainting
- ☐ Cold hands/feet
- ☐ Swelling of hands/feet
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Shortness of breath
- ☐ Varicose/spider veins
- ☐ Pressure in chest
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Spontaneous sweating
- ☐ Dizziness

RESPIRATORY

- ☐ Cough/Wheezing
- ☐ Coughing blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with deep inhalation
- ☐ Tight sensation in chest
- ☐ Difficult inhale/exhale
- ☐ Difficulty breathing when lying down
- ☐ Production of phlegm (what color?) _____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stool
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Bloating/Edema
- ☐ Chronic laxative use
- ☐ Loose stools (>2 per day)
- ☐ Abdominal pain/cramps
- ☐ Changes in appetite
- ☐ Acid reflux/GERD
- ☐ Hernia
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Significant thirst
- ☐ IBS/Crohn's Disease

GENITO-URINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgent urination
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Scanty flow
- ☐ Copious flow
- ☐ Impotence
- ☐ Sores on genitals
- ☐ Urinary tract infection
- ☐ Burning urination
- ☐ Decreased libido
- ☐ Dribbling after urination
- ☐ Herpes
- ☐ Infections
- ☐ Night urination

What time?_____ How often?_____

- ☐ Excessive libido

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Carpal Tunnel
- ☐ Knee pain
- ☐ Sprains/Strains
- ☐ Sciatica
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Tendonitis
- ☐ Back pain Low___ Middle___ Upper___
- ☐ Bursitis
- ☐ Rotator Cuff
- ☐ Soreness/weakness in lower body (back, knee, hip, ankle, foot)

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Loss of balance
- ☐ Vertigo/Dizziness
- ☐ Areas of numbness
- ☐ Lack of coordination
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety/Panic attacks
- ☐ Bad temper/irritable
- ☐ Easily susceptible to stress
- ☐ Seasonal Affective Disorder
- ☐ Nervousness
- ☐ ADD/ADHD
- ☐ Manic Depression

Have you ever been treated for emotional problems?
☐ Yes ☐ No

Have you ever considered or attempted suicide?
☐ Yes ☐ No

Have you ever been treated for substance abuse?
☐ Yes ☐ No

MEN

- ☐ Prostatitis
- ☐ Blood in semen
- ☐ Burning on ejaculation
- ☐ Low Libido
- ☐ Low Testosterone
- ☐ Vasectomy
- ☐ Pain or swelling of testicles
- ☐ Penis discharge
- ☐ Painful orgasm/intercourse
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Pain in testicles
- ☐ STDs/ Other Disorders: _____

WOMEN

- ☐ Difficult/Painful intercourse
- ☐ Ovarian cysts
- ☐ Vaginal dryness
- ☐ Endometriosis
- ☐ Date of last PAP/Pelvic _____
- ☐ Vaginal sores
- ☐ Uterine Fibroids
- ☐ Vaginal discharge
- ☐ Fibrocystic breast tissue
- ☐ Infertility
- ☐ Polycystic Ovarian Disease
- ☐ Irregular menstruation
- ☐ PMS
- ☐ Painful menstruation

At what age did you get your first period _____
Date of last menstrual cycle _____
Date of last PAP/Pelvic exam _____
Are you currently using birth control? ☐ Yes ☐ No
Are you pregnant now? ☐ Yes ☐ No

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Pregnancies (please include losses and terminations):

Year	Vaginal or C section	Complications or conditions of note

Have you experienced menopause? ☐Yes ☐No If so, when? _____
If you are experiencing menopausal symptoms, please describe: _____

Please answer the following based on your current menstrual cycle. If you have experienced menopause, please answer based upon symptoms present during menses:

Is your cycle regular? ☐Yes ☐No Number of days _____
Average number of days of flow _____
Flow is: ☐ Light ☐Normal ☐Heavy
Color is: ☐Pale ☐Normal ☐Dark ☐Bright Red ☐Brown
☐Blood clots
☐Pain or cramping, when? ☐Before ☐During ☐After
☐Nausea ☐Before ☐During ☐After
☐Vomiting ☐Before ☐During ☐After
☐Water retention
☐Food cravings
☐Breast tenderness/swelling
☐Mental depression
☐Irritability
☐Migraines
☐Headaches
☐Other _____
☐Spotting
☐Loose bowels
☐Abnormal PAP Smear
☐Cervical biopsy, operation, cauterization, conization? Result _____
☐Venereal disease
☐Yeast infections
☐Uterine fibroids, polyps, or endometriosis
☐Pelvic adhesions
☐Pelvic abnormalities
☐Sexually Transmitted Diseases/ Other Disorders: _____

Comments – Please inform me of any other concerns you would like to discuss.

_____
_____
_____
_____

Thank you for taking the time to complete the above questions. By answering, you are helping us better serve you.

Patient Signature Date

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PATIENT REGISTRATION (*PLEASE* PRINT CLEARLY)

Patient's Name: _____ SSN: _____

Date of Birth: _____ ____ Male ____ Female ____ Transgender

Marital Status: _____Single _____ Married _____ Partnered _____ Widowed _____ Divorced _____ Separated

Home Address: _____ Home Phone: _____

City/State/Zip Code: _____ Cell Phone: _____

E-mail Address: _____ Work Phone: _____

Patient's Employer: _____

Responsible Party: _____ Relationship: ____ Self ____ Spouse ____ Parent ____ Other

In Case of Emergency, contact: _____ Phone Number: _____

Relationship of Emergency Contact to Patient: _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company #1: _____ Phone Number (back of card): _____

Primary Insured's Name: _____ Date of Birth: _____

Member ID #: _____ Group # _____ Relationship: _____

Insurance Company #2: _____ Phone Number (back of card): _____

Primary Insured's Name: _____Date of Birth: _____

Member ID #: _____ Group # _____ Relationship: _____

- ✓ **I hereby authorize the payment of medical benefits to HEAL & CREATE WELLNESS, LLC and Leah Turner, L.Ac. for services rendered.**
- ✓ **I understand that I am financially responsible for any services not covered by my insurance carrier.**
- ✓ **I permit a copy of this authorization to be used in place of the original.**
- ✓ **I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.**
- ✓ **I hereby authorize CROSSINGS HEALING & WELLNESS, HEAL & CREATE WELLNESS, LLC and Leah Turner, L.Ac. to release any medical information necessary to complete and process my insurance claims.**

>>_____ _____

Patient's OR Insured's Signature (if patient is a minor, must have Responsible Party Signature) Date

I authorize the professional staff at **CROSSINGS HEALING & WELLNESS** and **HEAL & CREATE WELLNESS, LLC** to treat me and use my personal health information for healthcare operations.

>> _____ _____

Patient's Signature (OR parent if patient is a minor) Date