KenkoDo
735 Broadway
Somerville, MA 02144
617.666.0143

HEALTH HISTORY

Please take the time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

E-Mail: _____

Date of Birth: _____ Age: _____ Marital Status:_____

Referred by: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

In Emergency Notify: _____ Phone: _____

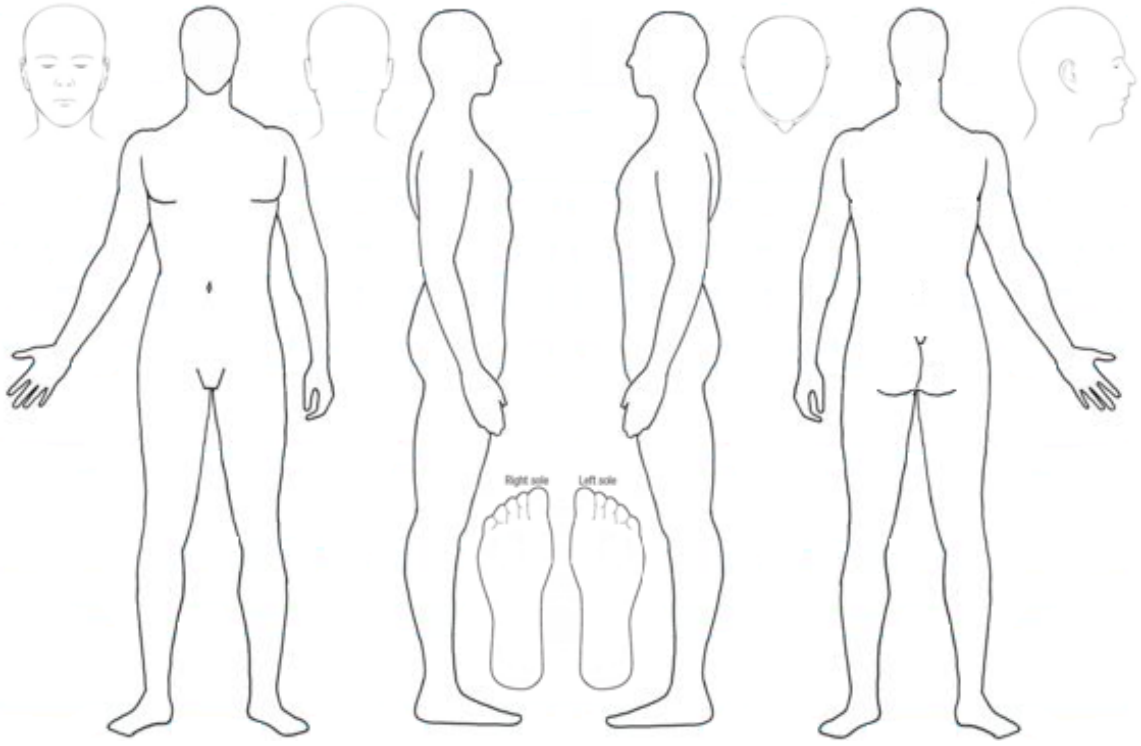
Main Complaint (*symptoms, diagnosis, duration, etc.*)**:**

Secondary Complaint (*symptoms, diagnosis, duration, etc.*)**:**

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, etc.):

What makes your condition worse? (Stress, fatigue, heat, certain foods, damp days etc.):

Please Mark Painful or Distressed Areas on the Chart Below



Significant Trauma (physical or emotional)**:**

Surgeries (please include date of procedure)**:**

Allergies (chemical, environmental, food, drugs, etc.)**:**

Medications (names & dosages) Please attach an additional page if necessary:

Vitamins/Supplements/Herbs:

Exercise :

Days per week	Length of workout	Type of Activity

Diet:

Meals per day	Snacks	Caffeinated Drinks	Alcohol per week

Personal History

Please check any conditions or symptoms you have now.

Cancer: Where? _____ When? _____ Treatment: Chemo / Radiation / Surgery / Other _____

Thyroid Imbalance	**Alcoholism**	**Addiction**	**Lyme Disease**

Energy/Sleep

Poor Sleeping	**Fatigue**	**Sudden energy drop**	**Night Sweats**
Excessive Dreams	**Cannot fall to sleep**	**Wake easily**	

Skin and 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 nail**
Sweats Easily			

Head, Eyes, Ears, Nose and Throat

Dizziness	**Difficulty swallowing**	**Migraines Glasses**	**Respiratory Allergies**
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**	**Raynaud's Disease**
Anemia	**Bleed/Bruise easily**	**Stroke**	**Heart Attack**

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? _____	
Emphysema			

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	Ulcerative Colitis
Food Allergies/Intolerance	Diabetes	Liver/Gall Bladder Disease	Gastritis/Pancreatitis
Cravings	Weight loss/gain	Hypo/Hyperglycemia	Hepatitis
Strong thirst (for hot or cold drinks)			

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
Premature ejaculation	Decreased libido	Prostatitis	Dribbling after urination
Nocturnal emission	Pain in testicles	Herpes	Infections
Night urination: What time?_____ How often?_____		Kidney Disease	Excessive libido

Gynecological/Reproductive

Difficult/Painful intercourse	Ovarian cysts	Age of first menses _____
Vaginal dryness	Endometriosis	Date of last menses _____
Vaginal sores	Uterine Fibroids	Date of last PAP/Pelvic _____
Vaginal discharge	Fibrocystic breast tissue	Number of pregnancies _____
Infertility	Polycystic Ovarian Disease	Number of live births _____
Irregular menstruation	PMS	Number of miscarriages _____
Painful menstruation		Number of abortions _____

Do you practice birth control? ___ What type? _____ How long? _____

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
Chronic Pain Condition	Muscle weakness/fatigue	Arthritis	

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