RED CLOVER CLINIC

Health History & Questionnaire

Patient Information	Contact Information
Date _____	Home Phone _____
Name _____	Work Phone _____
Address _____	Other/Cell Phone _____
City, State, Zip _____	Email _____
Age _____ Birthdate _____	
Occupation _____	Another person we may contact if necessary:
Company Name _____	Name _____
Primary Physician _____	Relationship _____
Physician Phone Number _____	Home Phone _____
How did you hear about us? _____	Work Phone _____
_____	

Health History

What are your primary concerns for coming in for treatment?

1. _____
2. _____
3. _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications or food supplements you are taking:

_____

_____

List serious illnesses, accidents or surgeries:

_____

_____

Check illnesses that have occurred in blood relatives:

Diabetes High blood pressure Stroke

Cancer Heart disease Kidney disease

Circle symptoms you have or have had in the last year:

- Depression
- Difficulty in focusing
- Dizziness
- Easily startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/tiredness
- Headaches
- Loss of sleep/poor sleep
- Loss or gain of weight
- Nervousness/irritability
- Overwhelmed by life

Circle conditions you have or have had in the past:

- AIDS
- Allergies
- Anemia
- Arthritis
- Bleeding disorders
- Breast lump
- Cancer
- Diabetes

How long has it been since you have had a complete medical exam? _____

Health History...continued

Circle symptoms you have or have had in the last year:

Muscle/Joint/Bones

- Tremors or Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms or Hips
- Back or Legs
- Feet
- Neck
- Hands
- Shoulders
- Other _____

Eyes/Ears/Nose/Throat/Respiratory

- Asthma/Wheezing/Difficulty breathing
- Blurred or failing vision
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever/Allergies
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

Skin

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

Genitourinary

- Blood/pus in urine
- Frequent urination
- Dribbling or Inability to control urine
- Kidney infection/stones
- Lowered libido
- Infertility

Cardiovascular

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

Gastrointestinal

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gallbladder trouble
- Hemorrhoids
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

For Men Only

- Erectile dysfunction
- Penis discharge
- Prostate trouble

For Women Only

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? _____

Signature

The information on this form is correct to the best of my knowledge.

Signature _____ Date _____