Fenske Holistic Healthcare Center LLC (608) 836-8883

Patient Health History

Laser Therapy patients

Name_____ **Date**_____

Date of Birth _____ **Age** _____ **Height** _____ **Weight** _____

Occupation _____

Race/Ethnicity **(circle one): White/Caucasian Black/African Amer. Asian Hispanic/Spanish Native Hawaiian Amer. Indian**

What brings you to our office?_____

List your major health problems/concerns:

1. _____

_____

2. _____

_____

3. _____

_____

Describe the causes of these concerns (if known or suspected): _____

_____

_____

_____

Have you had the same (or similar) problem before *(circle one)*? **Y / N**

What activities aggravate your problem(s)? _____

_____

What activities improve your problem(s)? _____

_____

Are your problems getting progressively worse? **Y / N**

Are your problems interfering with *(check all that apply)*:

☐ Work ☐ Daily Routine ☐ Sleep ☐ Other _____

If your condition involves pain please characterize type:

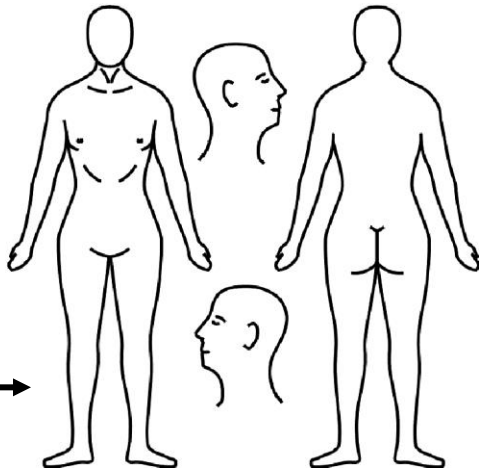
☐ Ache ☐ Sharp ☐ Radiating ☐ Constant ☐ Intermittent

Please rate the amount of pain you are generally experiencing:

(circle one) mild 1 2 3 4 5 6 7 8 9 10 severe

Please use the diagram to the right to indicate areas of involvement →

(mark: **P** *for pain,* **T** *for tightness,* **N** *for numbness).*



Previous Treatment for Health Problems

Were you previously treated for the above problems? **Y / N**
*(if no, skip to **Health Maintenance Update** section below)*
Name of practitioner _____
Date first seen_____ Date last seen_____
Condition or diagnosis_____
How was the condition treated_____
Results of treatment: ☐ Good ☐ Fair ☐ Poor

Please list below other practitioners seen for this condition: (or check here for none ____)

	Name	Date (approx.)	Testing/Treatment
1.			
2.			
3.			
4.			

Additional remarks about previous treatment _____
_____
Current primary care physician _____

Do you suffer from any other health problems from which you are not seeking consultation with us?
Y / N If yes, please itemize below:

	Condition	Date of onset (approx.)	Practitioner
1.			
2.			
3.			

Health Maintenance Update

Please indicate approximate dates and results of last:
Physical exam _____
Spinal exam _____
Dental exam _____
Cholesterol profile _____
Other blood tests _____
Chest X-ray _____
Spinal X-ray _____
Bone density (DEXA) scan _____
Mammogram _____
Eye exam _____
Colonoscopy or flexible sigmoidoscopy _____
Other _____

List all medications you are currently using, or have used recently. Include all over-the-counter medications. List dosages and approximate length of time you have used each medication:

_____
_____
_____
_____
_____

List (include name, brand, dosage) all vitamins, minerals, herbs, and other natural products you are currently using:

_____
_____
_____
_____
_____
_____
_____

List medication/supplement/environmental allergies or intolerances and associated reactions:

_____
_____
_____
_____
_____