Fenske Holistic Healthcare Center LLC

(608) 836-8883

PLEASE RETURN THIS FORM THREE WEEKS PRIOR TO YOUR INITIAL APPOINTMENT!

Patient Health History

Functional Medicine patients

Name_____ **Date**_____

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

Race/Ethnicity: ☐**Caucasian** ☐**African American** ☐**Asian** ☐**Hispanic** ☐**Native American** ☐**Other**

List your major health concerns along with the cause(s) and what improves or aggravates them (if known or suspected). Also include prior treatments:

1.

_____

_____

_____

_____

_____

2.

_____

_____

_____

_____

_____

3.

_____

_____

_____

_____

4.

_____

_____

_____

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

☐ Work ☐ Daily Routine ☐ Sleep ☐ Other _____

If your condition involves discomfort mark the table below with an 'X' in the appropriate box to indicate location, type and severity (using a scale of 1 to 10 with 10 being the most painful).

	Pain: ache	**Pain: sharp**	**Pain: radiating**	**Pain: constant**	**Pain: intermittent**	**Tight-ness**	**Numb-ness**	**Severity (1-10)**
Head								
Neck								
Upper back								
L shoulder								
R shoulder								
Mid back								
Low back								
Abdomen								
L hip								
R hip								
L knee								
R knee								
L ankle								
R ankle								
L foot								
R foot								
Other								

Comments: _____

Please list other practitioners seen for these concerns: (or check here for none: ☐)

Name Date (approx.) Testing/Treatment

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

Additional remarks about previous treatment:

_____

Current primary care physician _____

Health Maintenance Update

Please indicate approximate dates and results of last:

Physical exam _____

Dental exam _____

Blood tests _____

Eye exam _____

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:

_____

_____

_____

_____

List past or present exposure to harmful chemicals:

_____

_____

_____

Do you live/work in a damp or moldy home/office? _____

Do you have pets? _____

Illness / Conditions History

Please mark the appropriate box with an 'X' if these symptoms occur presently or have occurred in the past 6 months. Leave blank any spaces that do not apply.

GASTROINTESTINAL	Yes	Past
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Gallstones		
Other:_____		
RESPIRATORY		
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other: _____		
URINARY/GENITAL		
Kidney stones		
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other: _____		
ENDOCRINE/METABOLIC		
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyr.)		
Polycystic Ovarian Syndrome		
Infertility		
Metabolic syndrome/insulin resist.		
Eating disorder		
Hypoglycemia		
Other: _____		
INFLAMMATORY/IMMUNE		
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Hepatitis		
Other: _____		

MUSCULOSKELETAL	Yes	Past
Fibromyalgia		
Osteoarthritis		
Chronic pain		
Other: _____		
SKIN		
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other: _____		
CARDIOVASCULAR		
Angina		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, tri-glycerides)		
Rheumatic fever		
Arrythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other: _____		
NEUROLOGIC/EMOTIONAL		
Epilepsy/Seizures		
ADD/ADHD		
Headaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other: _____		
CANCER		
Lung		
Breast		
Colon		
Ovarian		
Skin		
Other: _____		

Surgical History

Please list all major and minor surgeries you have undergone with approximate dates:

_____

_____

_____

List Any Serious Accidents or Falls

_____

_____

Early Health History

List any known problems your mother had during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery):

_____

Were you breast fed? ☐ Yes ☐ No. If *yes*, please indicate duration if known _____

Was your home life as a child loving/supportive? ☐ Yes ☐ No

If there were significant stresses please describe

_____

Please check if you had any of the following childhood illnesses:

☐ Frequent ear infections ☐ Colic ☐ Eczema ☐ Recurrent colds ☐ Bronchitis

☐ Pneumonia ☐ Meningitis ☐ Other _____

As a child were you on frequent or prolonged antibiotic therapy? ☐ Yes ☐ No

Did you receive immunizations? ☐ Yes ☐ No

Did you experience any adverse reactions to immunizations? ☐ Yes ☐ No ☐ NA

If *yes*, please describe _____

Symptom Review

Please check the appropriate box for any symptoms that occur presently or have occurred in the last 6 months. Leave blank any spaces that do not apply.

GENERAL	Mild	Moderate	Severe
Cold hands and feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			

Flushing			
Heat intolerance			
Night waking			
Nightmare			
Can't remember dreams			
Low body temperature			

(continued)

HEAD, EYES, and EARS	Mild	Moderate	Severe
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear ringing/buzzing			
Eye crusting			
Eyelid margin redness			
Hearing loss			
Hearing problems			
Sensitivity to loud noises			
Vision problems			
MUSCULOSKELETAL	Mild	Moderate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches:			
Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES	Mild	Moderate	Severe
Difficulty:			
Concentrating			
With balance			
With thinking			
With speech			
With memory			
Dizziness (spinning)			
Light-headedness			
Seizures			
Tingling			
Tremor/trembling			

URINARY	Mild	Moderate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Urgency			
DIGESTION	Mild	Moderate	Severe
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of:			
Lower abdomen			
Whole abdomen			
Bloating after meals			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/ poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
Fissures			
Foods “repeat” (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to:			
Lactose			
All dairy products			
Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/ jaundice (yellow eyes or skin)			
Lower abdominal pain			

(continued)

Mucus in stools			
Nausea			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
EATING	Mild	Moderate	Severe
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt cravings			
Frequent dieting			
Sweet cravings			
Caffeine dependency			
RESPIRATORY	Mild	Moderate	Severe
Bad breath			
Bad odor in nose			
Cough – dry			
Cough – productive			
Hay fever:			
Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
NAILS	Mild	Moderate	Severe
Brittle			
Curve up			
Frayed			
Fungus – fingers			
Fungus – toes			

Pitting			
Ridges			
Soft			
Thickening of:			
Finger nails			
Toenails			
White spots/lines			
LYMPH NODES	Mild	Moderate	Severe
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
SKIN, DRYNESS of	Mild	Moderate	Severe
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
SKIN PROBLEMS	Mild	Moderate	Severe
Acne on back			
Acne on chest			
Acne on face			
Athlete's foot			
Bumps on back of upper arms			
Dark circles under eyes			
Ears get red			
Easy bruising			
Herpes – genital			
Hives			
Jock itch			
Pale skin			
Skin darkening			
Vitiligo			

(continued)

FEMALE REPRODUCTIVE	Mild	Moderate	Severe
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Yeast infections			
Unwanted hair growth			
Vaginal pain			
Premenstrual:			
Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual:			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Female Health History

Age at first period ____

Date of last period _____

Number of pregnancies ____

Number of live births ____

Menstrual cycle length: ____ days.

Duration of menstrual period: ____ days.

If you use birth control, what form do you use? _____

Digestive Function

Describe any food reactions you have: _____

_____

_____

Your usual bowel movement frequency is (*check one*):

☐ >2 times daily ☐ 1 time daily ☐ 1time every 2 days ☐ <1 time every 2 days.

Family Health History

Review the conditions below. Indicate if a family member has ever had a condition by marking the appropriate box with an 'X'. Leave blank any spaces that do not apply.

CONDITION **current age(s) >**	**Father**	**Mother**	**Spouse**	**Brother(s)**	**Sister(s)**	**Children**
Acne						
Alcoholism/addiction						
Allergies/hay fever						
Alzheimer's Disease / Dementia						
Arthritis						
Asthma						
Autoimmune disease						
Bedwetting						
Cancer (*specify type* _____)						
Depression						
Diabetes						
Digestive problems						
Ear infections						
Female problems						
Headaches						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problems						
Migraine						
Muscle pain/cramps						
Osteoporosis						
Spinal curve						
Thyroid problems						
Other (*specify* _____)						
Other (*specify* _____)						
If any of the above family members are deceased, specify cause of death…						
…and list their age at death						
Other pertinent family history:						

Stress Factors

Please indicate if any of the major stresses listed below apply to you *(check all that apply)*:
☐ Job ☐ New retirement ☐ New baby ☐ Change of marital status ☐ Health problems
☐ Family stress ☐ Financial concerns ☐ Abusive relationship ☐ Other: _____

Please describe the quality of major relationships in your life: _____

_____

Indicate job satisfaction: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ NA
Have you experienced physical, emotional, sexual, or verbal abuse? ☐ Yes ☐ No
How do you relax or relieve stress? _____

_____

Are you currently in therapy? ☐ Yes ☐ No
If yes, describe. _____

Lifestyle/Diet Habits

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No
Describe your sleep pattern: Time arise _____ Time retire _____ Naps? ☐ Yes ☐ No
Your quality of sleep is: ☐ Well-rested ☐ Tired upon awakening ☐ Awaken during night
Do you: ☐ Sleep in total darkness ☐ Sleep near electric clock, outlet, or other electronic device
What is the frequency of your vacations: ____ times / year.
Do you exercise? ☐ Yes ☐ No
If *yes*… Type: _____ Frequency: ____ x per ☐ week / ☐ month (*check one*).
Do you use tobacco? ☐ Yes ☐ No If *yes*, list amount you smoke/chew per day or week _____
Years using tobacco _____, if you no longer use it, when did you quit _____
Do you use recreational drugs? ☐ Yes ☐ No
If *yes*, list type and frequency _____
Did you formerly use recreational drugs? ☐ Yes ☐ No If *yes*, specify _____
How frequently do you dine out: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/never
How frequently do you eat fast food: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/never
How much water do you drink daily: ☐ < 1 qt. ☐ 1 qt. ☐ 2 qt. ☐ > 2qt.
Is it filtered water? ☐ Yes ☐ No
Foods you avoid and why
(*i.e.* allergies, diet, dislike): _____
Foods you crave: _____
Do you have (or have you had) an eating disorder? ☐ Yes ☐ No

Do you drink coffee? ☐ Yes ☐ No

If *yes*, how many daily cups daily of decaf? _____ and caffeinated? _____

Do you drink tea? ☐ Yes ☐ No

If *yes*, what kind? _____ and how many cups do you drink daily? _____

Do you drink soda? ☐ Yes ☐ No

If *yes*, what kind? _____ and how many do you drink daily? _____

Do you drink alcohol? ☐ Yes ☐ No

If *yes*, list type and amount per day and week _____

Do you have (or have you had) a problem with alcohol or drug overuse? ☐ Yes ☐ No

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take several nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Keep a record of everything you eat each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (e.g., work demands, sleep habits)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? _____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as a you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments _____

_____

When was the last time you felt well? _____

_____

Are there any other health goals you would like to achieve?

_____

_____

Is there anything else you would like to add?