

For Office Use Only:

- Bloomington Natural Care Center
- Burnsville Natural Care Center
- Woodwinds Natural Care Center
- Edith Davis Teaching Clinic
- University Health Service

Date: _____

Account Number: _____

Your Name: _____
(Last, First, Middle Initial)

Primary Healthcare Provider and/or Clinic: _____

Address: _____

Phone: _____

Your answers to the following questions will help us learn more about you and your health. Please take a few minutes to complete this questionnaire; you may skip any questions you are uncomfortable answering.

1. What is your chief complaint today? _____

Check all that apply.

- 1Neck / Back / Joint pain
- 2Headaches
- 3Depression / Anxiety
- 4Respiratory Problems (e.g., asthma, allergies, sinus congestion)
- 5Digestive Problems (e.g., poor appetite, heartburn, constipation, diarrhea)
- 6Urinary Problems (e.g., difficult or painful urination, kidney stones)
- 7Fatigue or low energy
- 8Female reproductive health (e.g., PMS, menopause, infertility)
- 9Male reproductive health (e.g., enlarged prostate, erectile dysfunction)
- 10.....Stress management
- 11.....General wellness
- 12Other: _____

Please mark on the body forms with an "X" where you are experiencing any pain or other discomfort. Next to the "X", use the symbols to indicate the **type of pain** you have experienced in the past week.

NUMBNESS
=====

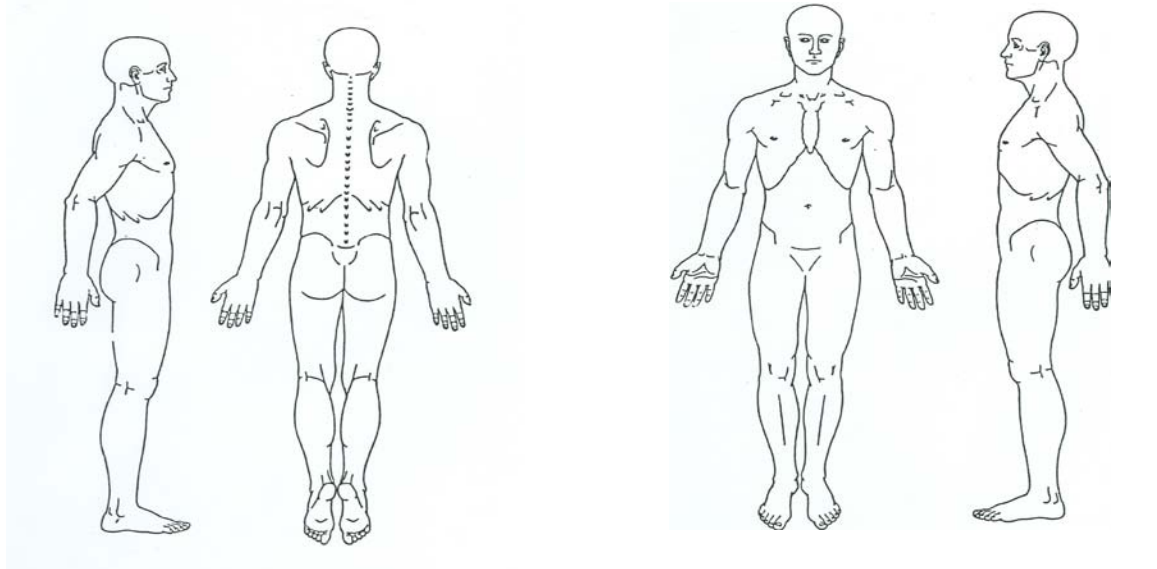
PINS AND NEEDLES
00000

BURNING
XXXXX

STABBING
/////

ACHING
+++++

OTHER



2. Health History

Please list any health problems you currently have or have had. Answer to the best of your knowledge.

Cancer (malignant or metastatic):

Diabetes (Type I or II):

Infectious Diseases (e.g. hepatitis, HIV):

Heart, Lungs and Circulation (e.g. asthma, high blood pressure, previous heart attack):

Digestive System (e.g. poor appetite, heartburn, constipation, diarrhea):

Psychosocial Health (e.g. depression, anxiety, violence toward self or others):

Skeleton and joints (e.g. arthritis, back or neck pain):

Genitourinary System (e.g. difficult or painful urination, kidney stones, sexually transmitted diseases):

Nervous System (e.g. headache, dizziness, multiple sclerosis, Parkinson's disease):

Eyes, ears, nose, and throat (e.g. loss of vision or hearing, ringing in ears, severe dental problems):

Skin (e.g. rashes, sores, moles that have changed):

Chronic Immune System deficiencies (e.g. colds, sinusitis, bronchitis):

Men's Health problems (e.g. enlarged prostate, erectile dysfunction):

Women's Health problems (e.g. dysmenorrheal, pelvic inflammatory disease, uterine fibroids):

Other: _____

Family health History

Do/did any members of your immediate family (mother, father, sister, brother) have any serious health conditions?

- No
- Yes → Please describe your relation to this individual and their condition

Please list any allergies:

Please list any surgeries you have had in the past, and their date:

Please list any traumas or injuries:

Please list:

Current Medications	Dose	Purpose	Prescribed by:

How many children do you have? _____

Females only, please list:

Number of pregnancies _____

Number of births _____

Have you had preventive health screenings for the following (check all that apply):

- | | | | | | | |
|--|--------------------------------|-----------------------------------|-------------------------------|----------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> blood pressure within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |
| <input type="checkbox"/> breast exam within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |
| <input type="checkbox"/> Pap smear within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |
| <input type="checkbox"/> prostate exam within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |
| <input type="checkbox"/> colonoscopy within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |
| <input type="checkbox"/> fasting blood glucose within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |
| <input type="checkbox"/> cholesterol within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |
| <input type="checkbox"/> blood lipids within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |
| <input type="checkbox"/> dental within the last | <input type="checkbox"/> month | <input type="checkbox"/> 6 months | <input type="checkbox"/> year | <input type="checkbox"/> 5 years | <input type="checkbox"/> 5+ years | <input type="checkbox"/> Never |

3. How often do you typically consume alcoholic drinks (e.g. beer, wine)?

- every day some days not at all

4. How often do you typically consume caffeinated drinks (e.g. coffee, soda)?

- every day some days not at all

5. Do you use tobacco products (e.g. cigarettes, chewing tobacco, pipe)?

- Yes, currently Yes, in the past (Year quit _____) No, never

6. On average, how much physical activity, exercise, or sports activities have you taken part in during the past month?

- None Less than 1 time/week 1 time/week 2-3 times/week 4 or more times/week

Please reflect on your sense of well-being, taking into account your physical, mental, emotional, social and spiritual condition over the past month. Mark the line below with an **X** at the point that summarizes your overall sense of well-being for the past month.

Worst you have
ever been

Best you have
ever been

7. What is your marital status? (Please check most current status)

- ₁Married or living with significant other
₂Divorced/Separated
₃Widowed
₄Never been married

8. How much schooling have you completed? (Please check one)

- ₁Completed less than high school
₂Graduated from High School
₃Completed 1-3 years of college
₄Graduated from a 2-year Associate degree program or technical school
₅Graduated from college
₆Completed post-graduate or professional program

9. Please identify your race, as defined by the federal government. (Please check one)

- ₁Asian or Pacific Islander
₂Black/African American
₃Hispanic
₄American Indian or Alaskan Native
₅White
₆Other _____