# TRUCARE HEALTH MEDICAL CENTER

# FOR

# INTEGRATIVE, FUNCTIONAL MEDICINE, & WELLNESS

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## COMPREHENSIVE HEALTH HISTORY FORM

TruCare Health

# COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the TruCare Health Team during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date:_____

First Name:_____ Middle:_____Last:_____

Address _____ City _____ State _____ Zip Code_____

Home Phone (____) _____-_____ Work (____) _____-_____ Cell (____) ____-_____

Email _____

Age _____ Date of Birth ____/____/_____ Place of birth_____ Gender: Female__Male___
City or town & country, if not US

Referred by:_____

Name, address, & phone number of primary care physician:_____

_____

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: _____
Relationship Name Phone

_____
Address

Occupation _____ Hours per week _____ Retired _____

Student _____

## CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

| Problem | Date of Onset | Severity/Frequency | Treatment Approach | Success |
|---|---|---|---|---|
| **Example:** Headaches | May 2016 | 2 times per week | Acupuncture/Aspirin | Mild improvement |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

When was the last time that you felt well?_____

What seems to trigger your symptoms?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

_____

_____

How much time have you lost from work or school in the past year due to these conditions?_____

## PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

| ILLNESSES | WHEN /ONSET | COMMENTS |
|---|---|---|
| Anemia | | |
| Arthritis | | |
| Asthma | | |
| Bronchitis | | |
| Cancer | | |
| Chicken Pox | | |
| Chronic Fatigue Syndrome | | |
| Crohn's Disease or Ulcerative Colitis | | |
| Diabetes | | |

| ILLNESS | WHEN/ONSET | COMMENTS |
|---|---|---|
| Emphysema | | |
| Epilepsy, convulsions, or seizures | | |

| | | |
|---|---|---|
| Gallstones | | |
| German Measles | | |
| Gout | | |
| Heart Attack, Angina | | |
| Heart Failure | | |
| Hepatitis | | |
| Herpes Lesions/Shingles | | |
| High blood fats (cholesterol, triglycerides) | | |
| High blood pressure (hypertension) | | |
| Irritable bowel (or chronic diarrhea) | | |
| Kidney stones | | |
| Measles | | |
| Mononucleosis | | |
| Mumps | | |
| Pneumonia | | |
| Rheumatic Fever | | |
| Sinusitis | | |
| Sleep Apnea | | |
| Stroke | | |
| Thyroid disease | | |
| Whooping Cough | | |
| Other (describe) | | |
| Other (describe) | | |
| **INJURIES** | **WHEN** | **COMMENTS** |
| Back injury | | |
| Broken bones or fractures (describe) | | |
| Head injury | | |
| Neck injury | | |
| Other (describe) | | |
| Other (describe) | | |

| DIAGNOSTIC STUDIES | WHEN | COMMENTS |
|---|---|---|
| Blood Tests | | |
| Bone Density Test | | |
| Bone Scan | | |
| Carotid Artery Ultrasound | | |
| CAT Scan (Please indicate type) | | |

| | | |
|---|---|---|
| Colonoscopy | | |
| EKG | | |
| Liver Scan | | |
| Mammogram | | |
| Neck X-Ray | | |
| MRI | | |
| X-Ray (Please indicate type) | | |
| Other (describe) | | |
| Other (describe) | | |
| **SURGERIES** | **WHEN** | **COMMENTS** |
| Appendectomy | | |
| Dental Surgery | | |
| Gall Bladder | | |
| Hernia | | |
| Hysterectomy | | |
| Tonsillectomy | | |
| Tubes in Ears | | |
| Other (describe) | | |
| Other (describe) | | |

## HOSPITALIZATIONS

| WHERE HOSPITALIZED | WHEN | REASON |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## MEDICATIONS

| How often have you taken antibiotics? | Less than 5 times | More than 5 times | Comments |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

| How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc) | Less than 5 times | More than 5 times | Comments |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

**List all medications. Include all over the counter non-prescription drugs.**

| Medication Name | Date started | Date stopped | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List all vitamins, minerals, and any nutritional supplements that you are taking now.**

| Type | Date Started | Date Stopped | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:_____

_____

## CHILDHOOD HISTORY

Please answer to the best of your knowledge.

| | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| Where you a full-term baby? | | | | |
| A premature birth? ('preemie') | | | | |
| Breast fed? | | | | |
| Bottle fed? | | | | |
| When pregnant with you, did your mother: | | | | |
| Smoke tobacco? | | | | |
| Use recreational drugs? | | | | |
| Drink alcohol? | | | | |
| Use estrogen? | | | | |
| Other prescription or non-prescription medications? | | | | |

## IMMUNIZATION HISTORY

| Please indicate if you have been vaccinated against any of the following diseases: | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| Smallpox | | | | |
| Tetanus | | | | |
| Diphtheria | | | | |
| Pertussis | | | | |
| Polio (oral) | | | | |
| Polio (injection) | | | | |
| Mumps | | | | |
| Measles | | | | |
| Rubella (German Measles) | | | | |
| Typhoid | | | | |
| Cholera | | | | |

## CHILDHOOD DIET

| Was your childhood diet high in: | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| Sugar? (Sweets, Candy, Cookies, etc) | | | | |
| Soda? | | | | |
| Fast food, pre-packaged foods, artificial sweeteners? | | | | |
| Milk, cheeses, other dairy products? | | | | |
| Meat, vegetables, & potato diet? | | | | |
| Vegetarian diet? | | | | |
| Diet high in white breads? | | | | |

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: milk – diarrhea)_____

_____

_____

**CHILDHOOD ILLNESSES:** Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

| | YES | AGE |
|---|---|---|
| ADD (Attention Deficient Disorder) | | |
| Asthma | | |
| Bronchitis | | |
| Chicken Pox | | |
| Colic | | |
| Congenital problems | | |
| Ear infections | | |

| | YES | AGE |
|---|---|---|
| Mumps | | |
| Pneumonia | | |
| Seasonal allergies | | |
| Skin disorders (e.g. dermatitis) | | |
| Strep infections | | |
| Tonsillitis | | |
| Upset stomach, digestive problems | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Fever blisters | | | | Whooping cough | | |
| Frequent colds or flu | | | | Other (describe) | | |
| Frequent headaches | | | | Other (describe) | | |
| Hyperactivity | | | | Measles | | |
| Jaundice | | | | | | |

As a child did you: Have a high absence from school? Yes___ No___

If yes, why?_____

Experience chronic exposure to second hand smoke in your home? Yes___ No___

Experience abuse Yes___ No___

Have alcoholic parents? Yes___ No___

## FEMALE MEDICAL HISTORY

*(For women only)*

**OBSTETRICS HISTORY:** Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____ ❑ Caesarean _____ ❑ Vaginal deliveries_____
- ❑ Miscarriage _____ ❑ Abortion _____ ❑ Living Children_____
- ❑ Postpartum depression___ ❑ Toxemia _____ ❑ Gestational diabetes_____

### GYNECOLOGICAL HISTORY

Age at first menses? _____ Frequency:_____ Length:_____

Painful: Yes_____ No_____ Clotting: Yes____ No____

Date of last menstrual period: ____/____/_____

Do you currently use contraception? Yes____ No____ If yes, what please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant._____

_____

_____

Are you menopausal? Yes_____ No_____ If yes, age of menopause_____

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

❑ Other _____

### DIAGNOSTIC TESTING

Last PAP test: _____/_____/_____ Normal:_____Abnormal_____

Last Mammogram_____/_____/_____ Breast biopsy? Date: _____/_____/_____

Date of last bone density_____/_____/_____ Results: High____ Low____ Within normal range____

## MALE MEDICAL HISTORY

*(For men only)*

Do you urinate without straining? Yes _____ No _____
Do you have a good urine flow rate? Yes _____ No _____
Do you have problems with frequency during the day or night? Yes _____ No _____
History of BPH (Benign Prostatic Hypertrophy) or other prostate problems Yes _____ No _____
History of Prostate or Breast Cancer? Yes _____ No _____
Family history of Prostate Cancer? Yes _____ No _____
History of DVT or blood clots in legs or lungs? Yes _____ No _____
History of Polycythemia? (Disease caused by your body making too many red blood cells) Yes ____ No ____
History of Hormone problems or low testosterone levels? Yes _____ No _____
If yes, what and how was it treated?
Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____
Change in libido? Yes_____ No_____

### DIAGNOSTIC TESTING

Last Prostate exam _____/_____/_____ Normal:_____Abnormal_____

Last PSA _____/_____/_____ Normal:_____Abnormal_____

PSA Level:

❑ 0 – 2
❑ 2 – 4
❑ 4 – 10
❑ >10

## FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

| Check Family Members that Apply | Father | Mother | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|---|---|
| Age (if still living) | | | | | | | | | |
| Age at death (if deceased) | | | | | | | | | |
| Heart Attack | | | | | | | | | |
| Stroke | | | | | | | | | |
| Uterine Cancer | | | | | | | | | |
| Colon Cancer | | | | | | | | | |
| Breast Cancer | | | | | | | | | |

| Ovarian Cancer | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Prostate Cancer | | | | | | | | | |
| Skin Cancer | | | | | | | | | |
| ADD/ADHD | | | | | | | | | |
| ALS or other Motor Neuron Diseases | | | | | | | | | |
| Alzheimer's | | | | | | | | | |
| Anemia | | | | | | | | | |
| Anxiety | | | | | | | | | |
| Arthritis | | | | | | | | | |
| Asthma | | | | | | | | | |
| Autism | | | | | | | | | |
| Autoimmune Diseases (such as Lupus) | | | | | | | | | |
| Bipolar Disease | | | | | | | | | |
| Bladder disease | | | | | | | | | |
| Blood clotting problems | | | | | | | | | |
| Celiac disease | | | | | | | | | |
| Dementia | | | | | | | | | |
| Depression | | | | | | | | | |
| Diabetes | | | | | | | | | |
| Eczema | | | | | | | | | |
| Emphysema | | | | | | | | | |
| Environmental Sensitivities | | | | | | | | | |
| **Check Family Members that Apply** | **Father** | **Mother** | **Brother(s)** | **Sister(s)** | **Children** | **Maternal Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** |
| Epilepsy | | | | | | | | | |
| Flu | | | | | | | | | |
| Genetic Disorders | | | | | | | | | |
| Glaucoma | | | | | | | | | |
| Headache | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| High Cholesterol | | | | | | | | | |
| Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis) | | | | | | | | | |
| Inflammatory Bowel Disease | | | | | | | | | |
| Insomnia | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Irritable Bowel Syndrome | | | | | | | | | |
| Kidney disease | | | | | | | | | |
| Multiple Sclerosis | | | | | | | | | |
| Nervous breakdown | | | | | | | | | |
| Obesity | | | | | | | | | |
| Osteoporosis | | | | | | | | | |
| Other | | | | | | | | | |
| Parkinson's | | | | | | | | | |
| Pneumonia/Bronchitis | | | | | | | | | |
| Psoriasis | | | | | | | | | |
| Psychiatric disorders | | | | | | | | | |
| Schizophrenia | | | | | | | | | |
| Sleep Apnea | | | | | | | | | |
| Smoking addiction | | | | | | | | | |
| Stroke | | | | | | | | | |
| Substance abuse (such as alcoholism) | | | | | | | | | |
| Ulcers | | | | | | | | | |

## PAIN ASSESSMENT

Are you currently in pain? Yes ___ No___

Is the source of your pain due to an injury? Yes___ No___

***If yes***, please describe your injury and the date in which it occurred: _____

_____

***If no***, please describe how long you have experienced this pain and what you believe it is attributed to: _____

Please List and Rate the severity of your pain.

(0= no pain, 10= severe pain)

Example: List Area of Pain: **Neck**

0 1 2 3 4 5 (6) 7 8 9 10

List Area of Pain_____

1 2 3 4 5 6 7 8 9 10

List Area of Pain. _____

1 2 3 4 5 6 7 8 9 10

List Area of Pain. _____

1 2 3 4 5 6 7 8 9 10

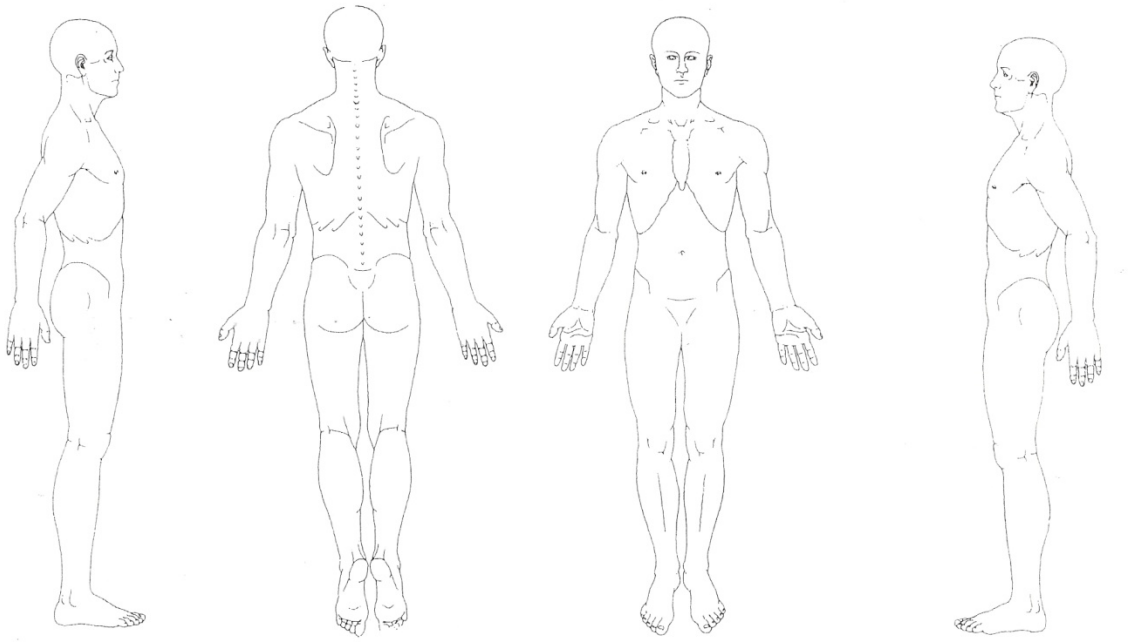
List Area of Pain. _____

1 2 3 4 5 6 7 8 9 10

Use the following letters provided to mark your area(s) of pain on the illustration.

Example: Place an **A** on the left shoulder to indicate an Ache you are currently experiencing

**A** = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting



Right Side Back Front Left side

## DENTAL HISTORY

| | Yes | No |
|---|---|---|
| Problem with sore gums (gingivitis)? | | |
| Ringing in the ears (tinnitus)? | | |
| Have TMJ (temporal mandibular joint) problems? | | |
| Metallic taste in mouth? | | |
| Problems with bad breath (halitosis) or white tongue (thrush)? | | |
| Previously or currently wear braces? | | |
| Problems chewing? | | |
| Floss regularly? | | |
| Do you have amalgam dental fillings? How many? | | |
| Did you receive these fillings as a child? | | |

List your approximate age and the type of dental work done from childhood until present:

| Age | Type of dental work: | Health Problems following dental work? (describe) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____

## FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

| Usual Breakfast | Usual Lunch | Usual Dinner |
|---|---|---|
| ❑ None | ❑ None | ❑ None |
| ❑ Bacon/Sausage | ❑ Butter | ❑ Beans (legumes) |
| ❑ Bagel | ❑ Coffee | ❑ Brown rice |
| ❑ Butter | ❑ Eat in a cafeteria | ❑ Butter |
| ❑ Cereal | ❑ Eat in restaurant | ❑ Carrots |
| ❑ Coffee | ❑ Fish sandwich | ❑ Coffee |
| ❑ Donut | ❑ Fried foods | ❑ Fish |
| ❑ Eggs | ❑ Hamburger | ❑ Green vegetables |
| ❑ Fruit | ❑ Hot dogs | ❑ Juice |
| ❑ Juice | ❑ Juice | ❑ Margarine |
| ❑ Margarine | ❑ Leftovers | ❑ Milk |
| ❑ Milk | ❑ Lettuce | ❑ Pasta |
| ❑ Oat bran | ❑ Margarine | ❑ Potato |
| ❑ Sugar | ❑ Mayo | ❑ Poultry |
| ❑ Sweet roll | ❑ Meat sandwich | ❑ Red meat |
| ❑ Sweetener | ❑ Milk | ❑ Rice |
| ❑ Tea | ❑ Pizza | ❑ Salad |
| ❑ Toast | ❑ Potato chips | ❑ Salad dressing |
| ❑ Water | ❑ Salad | ❑ Soda |
| ❑ Wheat bran | ❑ Salad dressing | ❑ Sugar |
| ❑ Yogurt | ❑ Soda | ❑ Sweetener |
| ❑ Oat meal | ❑ Soup | ❑ Tea |
| ❑ Milk protein shake | ❑ Sugar | ❑ Vinegar |
| ❑ Slim fast | ❑ Sweetener | ❑ Water |
| ❑ Carnation shake | ❑ Tea | ❑ White rice |
| ❑ Soy protein | ❑ Tomato | ❑ Yellow vegetables |
| ❑ Whey protein | ❑ Vegetables | ❑ Other: (List below) |
| ❑ Rice protein | ❑ Water | |
| ❑ Other: (List below) | ❑ Yogurt | |
| | ❑ Slim fast | |
| | ❑ Carnation shake | |
| | ❑ Protein shake | |

Please list your diet for the last three days and indicate estimated times

| Day 1 | Day 2 | Day 3 |
|---|---|---|
| ❑ Breakfast / Time | ❑ Breakfast / Time | ❑ Breakfast / Time |
| ❑ Lunch / Time | ❑ Lunch / Time | ❑ Lunch / Time |
| ❑ Dinner / Time | ❑ Dinner / Time | ❑ Dinner / Time |
| ❑ Snack / Time | ❑ Snack / Time | ❑ Snack / Time |
| ❑ Snack / Time | ❑ Snack / Time | ❑ Snack / Time |
| ❑ Snack / Time | ❑ Snack / Time | ❑ Snack / Time |
| ❑ Beverages | ❑ Beverages | ❑ Beverages |

How much of the following do you consume each week?

| | |
|---|---|
| Candy | |

| | |
|---|---|
| Cheese | |
| Chocolate | |
| Cups of coffee containing caffeine | |
| Cups of decaffeinated coffee or tea | |
| Cups of hot chocolate | |
| Cups of tea containing caffeine | |
| Diet soda | |
| Ice cream | |
| Salty foods | |
| Slices of white bread (rolls/bagels, etc) | |
| Soda with caffeine | |
| Soda without caffeine | |

Do you currently follow a special diet or nutritional program? Yes____ No_____

- ❑ Ovo-lacto
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Gluten Free
- ❑ FODMAPs
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet
- ❑ Other (describe)_____

Please tell us if there is anything special about your diet that we should know._____

_____

Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc?
Yes___ No____
If yes, are these symptoms associated with any particular food or supplement?
Yes___ No____
If yes, please name the food or supplement and symptom(s). _____

_____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc.? (symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals greatly affect your symptoms? Yes _____ No _____

If yes, do you feel better immediately eating? Yes _____ No _____

Do you feel tired immediately after eating? Yes _____ No _____

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes _____ No _____ If yes, what food(s) _____

_____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) _____

_____

Please complete the following chart as it relates to your bowel movements:

| Frequency | √ | Color | √ |
|---|---|---|---|
| More than 3x/day | | Medium brown consistently | |
| 1-3x/ day | | Very dark or black | |
| 4-6x/week | | Greenish color | |
| 2-3x/week | | Blood is visible | |
| 1 or fewer x/week | | Varies a lot | |
| | | Dark brown consistently | |
| **Consistency** | **√** | Yellow, light brown | |
| Soft and well formed | | Greasy, shiny appearance | |
| Often floats | | | |
| Difficult to pass | | | |
| Diarrhea | | | |
| Thin, long or narrow | | | |
| Small and hard | | | |
| Loose but not watery | | | |
| Alternating between hard and loose/watery | | | |

Intestinal gas:

- ❑ Daily
- ❑ Occasionally
- ❑ Excessive
- ❑ Present with pain
- ❑ Foul smelling
- ❑ Little odor

# LIFESTYLE HISTORY

## TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much?_____

Number of years?_____If not a current user, year quit_____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain:

_____

## ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From_____ to _____

## OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes____ No____

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

## SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?

## EXERCISE HISTORY

Do you exercise regularly? Yes____ No____

If yes, please indicate:

| Type of exercise | Times/week | | | | Length of session | | | |
|---|---|---|---|---|---|---|---|---|
| | 1x | 2x | 3x | 4x/+ | ≤15 | 16-30 min | 31-45 min | >45 |
| Jogging/Walking | | | | | | | | |
| Aerobics | | | | | | | | |
| Strength Training | | | | | | | | |
| Pilates/Yoga/Tai Chi | | | | | | | | |
| Sports (tennis, golf, water sports, etc) | | | | | | | | |
| Other (please indicate) | | | | | | | | |

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

_____

_____

## STRESS / PSYCHOSOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc.)_____

Did it help?_____

How well have things been going for you?

| | Very well | Fine | Poorly | Very poorly | Does not apply |
|---|---|---|---|---|---|
| At school | | | | | |
| In your job | | | | | |
| In your social life | | | | | |
| With close friends | | | | | |
| With sex | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| With your attitude | | | | | |
| With your boyfriend/girlfriend | | | | | |
| With your children | | | | | |
| With your parents | | | | | |
| With your spouse | | | | | |

Which of the following provide you emotional support? *Check all that apply*

☐Spouse ☐Family ☐Friends ☐Religious/Spiritual ☐Pets ☐Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _____

Check all that apply:

☐Yoga ☐Meditation ☐Imagery ☐Breathing ☐Tai Chi ☐Prayer ☐Other

Hobbies and leisure activities:

_____

_____

Is there anything that you would like to discuss with the doctor that you feel you cannot indicate here?
Yes_____ No_____

## READINESS ASSESSMENT

*Rate on a scale of: 5 (very willing) to 1 (not willing). Please Circle*

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

| | | | | | |
|---|---|---|---|---|---|
| Significantly modify your diet | 5 | 4 | 3 | 2 | 1 |
| Take 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 relaxation techniques | 5 | 4 | 3 | 2 | 1 |
| Engage in regular exercise | 5 | 4 | 3 | 2 | 1 |
| Have periodic lab tests to assess progress | 5 | 4 | 3 | 2 | 1 |

Comments _____
_____
_____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and wellbeing.

Sincerely,
*Your TruCare Health Team*