

HEALTH INVENTORY

NAME \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

CURRENT SYMPTOMS: Please check any of the following that you are experiencing.

- Weakness, Palpitation, Depression, Crying Easily, Indecisiveness, Irritability, Personality Changes, Tiring Easily, Numbness, Shaky Hands, Lack of Interest, Anxiety, Family Problems, Seeing Thing, Paranoia, Low Self-esteem, Nightmares, Dry Mouth, Short tempered, Suicidal Feelings, Feelings of Hopelessness, Feelings of Guilt, Feelings of Inferiority, Hearing Voices, Poor Attention Span, Inability to Relax, Socially Withdrawn, Physical Complaints, Racing Heart, Constant Worry

HEALTH PROBLEMS: Have you ever had one of the following health problems? Please put month and year next to any items checked

- Weakness, Tension Headache, Migraine Headache, TMJ Disorder, Chronic Back Pain, Chest Pain or Angina, Abdominal Pain, Pelvic or Genital Pain, Arthritis, Bone Fracture, Concussion, Thyroid Disorder, Lack of Interest, Heart Attack or Heart Disorder, Lung or Respiratory Disease, Liver Disease or Hepatitis, Kidney Disorder or Kidney Stones, Urinary or Bladder Disorder, Skin Disorder, Eczema, Hives, High Blood Pressure, Low Blood Pressure, Sexually Transmitted Disease, Pre-Menstrual Syndrome or Menstrual Changes, Prostate or Vaginal Disorder, Feelings of Hopelessness, Epilepsy, Cancer, Insomnia, Asthma, Allergies, Peptic Ulcer, Colitis, Diabetes, Hypoglycemia, Deafness, Tinnitus

OTHER ILLNESSES: What other serious illnesses have you had? \_\_\_\_\_

CONDITIONS: Have you frequently experienced any of the following symptoms? Date of last physical exam \_\_\_\_/\_\_\_\_/\_\_\_\_

- Cold Hands or Feet, Swollen Ankles or Feet, Stiff, Aching Joints, Neck or Shoulder Tension, Grinding Your Teeth, Ringing in Ears, Rapid Heartbeat, Short-term Memory Loss, Excessive Sweating, Difficulty Sleeping, Overeating or Binge Eating, Under eating or Poor Appetite, Job Dissatisfaction, Sex Life Not Satisfying, Lack of Fun or Affection, Long-term Memory Loss, Colds or Flu, Sore Throat, Dizziness, Diarrhea, Constipation, Nausea, Vomiting, Hyperventilation, Blurred Vision

ACCIDENTS: Have you ever been injured in an accident? If yes, please elaborate:

\_\_\_\_\_

ITEMS: Do you have any of the following more than twice a day?

- Ice Cream, Cup of Coffee, Glass of Beer or Wine, Liquor or Cocktail, Can of Soda Pop, Recreational Drug, Cigarette, Chocolate

MEDICATIONS: Have you ever taken the following medications on a regular basis?

- Aspirin or Pain Reliever, Pain Relieving Drug, Sleeping Pill, Tranquilizer, Antidepressant, Blood Pressure Medication, Lithium, Anti-anxiety

Please list all medications that you are taking: Dose (how much? How often?) How taken? (pills, liquid, etc)

Please include all herbal remedies and any dietary supplements:

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Please inform me whenever current medications and/or dosages are changed, discontinued, or new medications are added.