

HEALTH INVENTORY

NAME _____

DATE ____/____/____

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

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 Socially Withdrawn |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

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

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

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

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Ice Cream | <input type="checkbox"/> Glass of Beer or Wine | <input type="checkbox"/> Can of Soda Pop | <input type="checkbox"/> Cigarette |
| <input type="checkbox"/> Cup of Coffee | <input type="checkbox"/> Liquor or Cocktail | <input type="checkbox"/> Recreational Drug | <input type="checkbox"/> Chocolate |

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

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Aspirin or Pain Reliever | <input type="checkbox"/> Sleeping Pill | <input type="checkbox"/> Antidepressant | <input type="checkbox"/> Lithium |
| <input type="checkbox"/> Pain Relieving Drug | <input type="checkbox"/> Tranquilizer | <input type="checkbox"/> Blood Pressure Medication | <input type="checkbox"/> 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:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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