Whispering Waters Wellness
Patient Health History

Name: _____Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____

Place of Birth: _____

Time of Birth: _____ AM/PM Time unknown (circle one)

(Whenever possible I use evolutionary astrology to gain a more complete understanding of how best to help you, for which accurate birth information is crucial. We can arrange for in-depth chart reading as well as transits/progressions covering current and upcoming events if you wish to look further into this.)

Address: _____

Email: _____

Phone: _____

Gender: M/F Marital status: S M D W

How did you hear of us? _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care?

_____

For what reason?

_____

_____

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2. Please identify the health concerns that have brought you to Whispering Waters Wellness in order of importance below:

Condition Past Treatment

a. _____ _____

How does this condition affect you?

_____

Condition Past Treatment

b. _____ _____

How does this condition affect you?

_____

Condition Past Treatment

c. _____ _____

How does this condition affect you?

_____

Condition Past Treatment

d. _____ _____

How does this condition affect you?

_____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

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5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N

If yes, please identify: _____

8. Health History:

Please check all those that are applicable and give a brief explanation (type, location, date of onset, current symptom, remission, etc.):

Cancer ☐ _____

Diabetes ☐ _____

Heart Disease ☐ _____

High Blood Pressure ☐ _____

Stroke ☐ _____

Mental Illness ☐ _____

Asthma/Hay fever/Hives ☐ _____

Kidney Disease ☐ _____

Anemia ☐ _____

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9. Height: _____Weight: Currently: _____ Past Maximum: _____
When? _____

10. Blood Pressure: Most recent blood pressure reading? _____/_____
When was this reading taken? _____

11. Childhood Illness (please circle any that you have had):

☐ Scarlet Fever ☐ Diphtheria ☐ Rheumatic Fever ☐ Mumps ☐ Measles

☐ German Measles ☐ Chicken Pox

Others:

_____

12. Hospitalizations and Surgeries:

Reason	When
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

14. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When
_____	_____
_____	_____
_____	_____

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15. Emotional (please circle any that you experience now and underline any that you have experienced in the past):

☐ Anxiety ☐ Anger ☐ Obsessive Thinking ☐ Mood Swings

☐ Nervousness ☐ Fear ☐ Sorrow/Grief ☐ Stress

Other: _____

16. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections

Chronic Fatigue Syndrome

17. Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Eye Pain/Strain Glaucoma Ear Ringing Earaches

Frequent Sore Throats Teeth Grinding Impaired Vision

Impaired Hearing Nose Bleeds Glasses/Contacts Headaches

TMJ/Jaw Problems Tearing/Dryness Sinus Problems Hay Fever

Other:

_____

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18. Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Persistent Cough Shortness of Breath

Frequent Common Colds Difficulty Breathing Emphysema

Pleurisy Asthma Tuberculosis

Other Respiratory Problems:

_____

19. Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever

Varicose Veins

Other:

_____

20. Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain

Passing Gas Heartburn Belching Gall Bladder Disease

Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Other:

_____

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21. Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI

Frequent Urination Heavy Flow Kidney Stones

Impaired Urination Blood in Urine Frequent Urination at Night
Other:

_____

22. Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Vaginal Discharge Menopausal Symptoms

Breast Lumps/Tenderness Premenstrual Problems

Difficulty Conceiving Nipple Discharge Clotting Painful Periods

Heavy Flow Bleeding Between Cycles
Other: _____

23. Menstrual/Birthing History:
Age of First Menses: _____ # of Days of Menses: _____

Length of Cycle: _____ Birth Control Type: _____

# of Pregnancies: _____ (Live Births: ____ Miscarriages: ____)

24. Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Prostrate Problems Sexual Difficulties Penile Discharge

Testicular Pain/Swelling

25. Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain

Upper Back Pain Mid Back Pain Low Back Pain Leg Pain

Joint Pain (if so, where?):

_____

26. Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling

Loss of Balance Seizures/Epilepsy

27. Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus

Night Sweats Feeling Hot or Cold

28. Other (please circle any that you experience now and underline any that you have experienced in the past):

Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know?

_____

_____

_____

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29. Lifestyle:

a. Do you typically eat at least three meals per day? Ⓨ Ⓝ
   If no, how many? _____
b. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
c. How often do you exercise?

   _____
d. How many hours per night do you sleep? _____ Do you wake rested? Ⓨ Ⓝ
e. Occupation:

   _____

   Hours/Week: _____

   Do you enjoy work? Ⓨ Ⓝ

   Why/Why not?

   _____
f. Nicotine/Alcohol/Caffeine Use:

   _____
g. Have you experienced any major traumas? Ⓨ Ⓝ
   Please Explain:

   -

   -

   -
h. Interests and hobbies: