A Mindful Approach to Health
Adult Health History Form
Dr. Leslie Burgess ND BCN

Patient Name:_____ Date of Birth:_____ Age: _____
Email:_____ Phone number: _____
Address:_____
Can we leave a message on your voicemail? ____
Emergency Contact Name: _____Phone Number: _____

PLEASE LIST MOST IMPORTANT HEALTH CONCERNS TODAY:
Goals to Accomplish:
1._____ 4._____
2._____ 5._____
3._____ 6._____

SYMPTOMS: (Check symptoms that you currently have or have had in the past year)

General
□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Loss of sleep
□ Loss of weight
□ Nervousness
□ Numbness
□ Sweats

Muscle/Joint/Bone
Pain, weakness, numbness in:
□ Arms □ Hips
□ Back □ Legs
□ Feet □ Neck
□ Hands □ Shoulders

Genito-Urinary
□ Blood in the urine
□ Lack of bladder control
□ Painful urination
□ Frequent urination

Gastrointestinal
□ Appetite poor
□ Bloating
□ Bowel changes
□ Constipation
□ Diarrhea
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal bleeding
□ Stomach pain
□ Vomiting
□ Vomiting blood

Cardiovascular
□ Chest pain
□ High Blood Pressure
□ Irregular Heart Beat
□ Low Blood Pressure
□ Poor circulation
□ Rapid heart beat
□ Swelling of ankles
□ Varicose veins

Eye, Ear, Nose, Throat
□ Bleeding Gums
□ Blurred Vision
□ Crossed eyes
□ Difficulty swallowing
□ Double vision
□ Earache
□ Ear discharge
□ Hay fever
□ Hoarseness
□ Loss of hearing
□ Nosebleeds
□ Persistent cough
□ Ringing in ears
□ Sinus problems
□ Vision – flashes or halos

Skin
□ Bruise easily
□ Hives
□ Itching
□ Change in moles
□ Rash
□ Scars
□ Sores that won't heal

Men only
□ Breast lump
□ Erection difficulties
□ Lump in testicles
□ Penis discharge
□ Sore on penis
□ Other

Women only
□ Abnormal Pap Smear
□ Bleed between periods
□ Breast lump
□ Extreme menstrual pain
□ Hot flashes
□ Nipple discharge
□ Painful intercourse
□ Vaginal discharge
□ Other
Date of Last Menstrual Period:_____
Have you had a mammogram?_____
Are you pregnant?____
Number of children___

CONDITIONS/SYMPTOMS: (Circle any conditions you currently have or have had in the past year)

AIDS or HIV	Chemical Dependency	Herpes	Polio
Alcoholism	Crohn's Disease	High Cholesterol	Prostate problems
Anemia	Diabetes Type 1 or 2	Kidney Disease	Psychiatric Care
Anorexia / Bulimia	Depression	Liver Disease	Rheumatic Fever
Anxiety(General)	Emphysema	Measles	Schizophrenia
Appendicitis	Epilepsy	Memory loss	Social Anxiety
Arthritis	Glaucoma	Migraines	Stroke
Asthma	Goiter	Miscarriages	Suicide Attempt

Bipolar Disorder	Gonorrhea	Mononucleosis	Thyroid problems
Bleeding disorders	Gout	Multiple Sclerosis	Tonsillitis
Border line personality	Grave's Disease	OCD	Tuberculosis
Breast lump	Heart Disease	Pacemaker	Ulcers
Bronchitis	Hepatitis	Pancreatitis	Ulcerative Colitis
Cancer	Hernia	Pneumonia	Vaginal infections/STDs

Medications or Supplements

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies (drug, food, environmental):

_____
_____
_____
_____
_____

What medications and supplements do you find to be most helpful and why?

_____
_____
_____
_____
_____
_____

Pharmacy name: _____ Phone:_____

HOSPITALIZATIONS/SURGERIES/ACCIDENTS/SERIOUS INJURIES: (Describe and give dates)

_____
_____
_____

Traumatic Brain Injuries (Describe and give dates**)**

_____
_____
_____

Circle symptoms associated with your TBI.

Anger	Memory Loss	Other:
Anxiety	Problems planning and coordinating tasks	
Depression	Vision Concerns	
Focus concerns	Word Finding problems	

PREGNANCIES

Year of Birth	Sex	Complications, if any
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: (Identify all family members who have or have had any of the following)

____Alcoholism	____Cancer	____High Blood Pressure	____Allergies
____Diabetes	____Hypoglycemia	____Anemia	____Eczema
____Mental Illness	____Arthritis	____Epilepsy	____Obesity
____Asthma	____Heart Disease	____Stroke	____Birth Defects
____Hearing Loss	____Thyroid Disorder	____High Cholesterol	

____Other_____

HEALTH HABITS:

Check which substances you use and describe how much you use

___Caffeine _____
___Tobacco _____
___Drugs _____
___Alcohol _____
___Other _____

OCCUPATIONAL:

Check if your work exposes you to the following:

____Stress ____Hazardous Substances
____Heavy Lifting
____Other

I certify that the above information is correct to the best of my knowledge:

Signature:_____ Date:_____