# DOGWOOD HEALING CENTER CLIENT INFORMATION FORM (Please Print)

## Health Questionnaire

Welcome to Dogwood Healing Center. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential in conformation with our Privacy Policy.

Today's Date _____ /_____ /_____

Name _____ Birthdate _____ /_____ /_____ Age _____ Gender ☐ M ☐ F

Address _____ City/State/Zip _____

Email _____ Referred by _____

Home Phone (_____)_____ Cell (_____)_____ Work Phone (_____)_____

Emergency Contact _____Relationship _____ Phone (_____)_____

Marital Status ☐ M ☐ D ☐ S ☐ W Occupation _____ Employer _____

Insurance _____ ProviderPolicy/ID # _____ Group # _____

Primary Care Physician _____ Phone (_____)_____ Last Physical _____ /_____ /_____

OB-GYN _____ Phone (_____)_____ Last PAP _____ /_____ /_____

Specialist(s) _____

May I contact these providers to ensure integrated care? ☐ Yes ☐ No Height _____ Weight _____

## Health Concern(s)

What brings you here today? _____

_____

How long have you been experiencing the condition? _____ Physician Diagnosis? _____

Is there a specific event that correlates to your condition? _____

Are you in pain today? ☐ Yes ☐ No What number best describes your pain today? (0 = no pain, 10 = severe) _____

Is your condition affected by seasonal changes? ☐ Yes ☐ No Describe the quality of pain _____

Medication for this condition (dosage)? _____ Is your condition affected by seasonal changes? ☐ Yes ☐ No

What improves your condition? _____ What makes your condition worse? _____

Is your condition consistent or come and go? _____ Does this condition affect your emotional health? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No What would you describe your general level of stress? _____

## Medical History

| | | | | |
|---|---|---|---|---|
| ☐ Allergies | ☐ Rheumatic Fever | ☐ High Blood Pressure | ☐ Diabetes | ☐ Cancer |
| ☐ Thyroid Disease | ☐ Venereal Disease | ☐ Hepatitis | ☐ Heart Disease | ☐ Accidents |
| ☐ Pacemaker | ☐ Organ Transplant | ☐ Multiple Sclerosis | ☐ Addison's Disease | ☐ Radiation/Chemotherapy |
| ☐ Surgical Implants | ☐ Adrenal Insufficiency | ☐ Alcohol/Substance Addiction | | |

Surgeries/Other Significant Illness (describe): _____

## Hair & Skin Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

| | | | |
|---|---|---|---|
| ☐☐ Rashes | ☐☐ Acne | ☐☐ Recent Moles | ☐☐ Hives |
| ☐☐ Eczema | ☐☐ Ulcerations | ☐☐ Itching | ☐☐ Redness/Rosacea |
| ☐☐ Psoriasis | ☐☐ Dandruff | ☐☐ Hair Loss | |

Other: _____

## Head, Eyes, Ears Nose & Throat Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

| | | | |
|---|---|---|---|
| ☐☐ Dizziness | ☐☐ Night Blindness | ☐☐ Headaches | ☐☐ Dry Mouth/Throat |
| ☐☐ Eye Pain | ☐☐ Bleeding Gums | ☐☐ Ringing in Ears | ☐☐ Migraines |
| ☐☐ Blurred Vision | ☐☐ Poor Hearing | ☐☐ Floaters in Eyes | ☐☐ Ear Aches |
| ☐☐ Lip/Tongue Sores | ☐☐ Jaw Clicking | ☐☐ Toothaches/Pain | ☐☐ Facial Pain |
| ☐☐ Nosebleeds | ☐☐ Recurrent Sore Throats | ☐☐ Teeth Grinding | |

Other: _____

## Cardiovascular Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

| | | | |
|---|---|---|---|
| ☐☐ Fainting | ☐☐ Blood Clots | ☐☐ Chest Pain | ☐☐ Palpitations |
| ☐☐ Low Blood Pressure | ☐☐ High Blood Pressure | ☐☐ Swelling of Hands/Feet | ☐☐ Irregular Heart Beat |

Other: _____

## Respiratory Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

| | | | |
|---|---|---|---|
| ☐☐ Cough | ☐☐ Bronchitis | ☐☐ Pain w/ Deep Breath | ☐☐ Coughing Blood |
| ☐☐ Pneumonia | ☐☐ Shortness of Breath | ☐☐ Asthma | ☐☐ Coughing Phlegm |
| ☐☐ Nasal Congestion | ☐☐ Trouble Breathing While Lying Down | | |

Other: _____

## Gastrointestinal & Abdominal Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

| | | | |
|---|---|---|---|
| ☐☐ Nausea | ☐☐ Bloating | ☐☐ Retention of Food | ☐☐ Blood in Stool |
| ☐☐ Vomiting | ☐☐ Belching | ☐☐ Lack of Appetite | ☐☐ Hemorrhoids |
| ☐☐ Diarrhea | ☐☐ Abdominal Pain/Cramps | ☐☐ Excess Appetite | ☐☐ Bad Breath |
| ☐☐ Constipation | ☐☐ Indigestion | ☐☐ Rectal Pain | ☐☐ Sensitive Abdomen |
| ☐☐ Gas | ☐☐ Heartburn/Reflux | ☐☐ Black Stools | ☐☐ Chronic Laxative Use |

Other: _____

## Urinary & Genital Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

☐☐ Urinary Pain ☐☐ Urgency to Urinate ☐☐ Decrease in Flow ☐☐ Blood in Urine

☐☐ Kidney Stones ☐☐ Sores on Genitals ☐☐ Frequent Urination ☐☐ Unable to Hold Urine

☐☐ Impotence ☐☐ Waking at Night to Urinate How many times? _____

Other: _____

## Musculoskeletal Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

☐☐ Neck Pain ☐☐ Foot/Ankle Pain ☐☐ Hand/Wrist Pain ☐☐ Sciatica

☐☐ Joint Pain ☐☐ Back Pain ☐☐ Shoulder Pain ☐☐ Muscle Weakness

☐☐ Bone Problems ☐☐ Knee Pain ☐☐ Hip Pain ☐☐ Muscle Pain

Other: _____

## Psychological & Neurological Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

☐☐ Seizures ☐☐ Areas of Numbness ☐☐ Concussion ☐☐ Bad Temper

☐☐ Dizziness ☐☐ Poor Memory ☐☐ Depression ☐☐ Easily Stressed

☐☐ Loss of Balance ☐☐ Lack of Coordination ☐☐ Anxiety ☐☐ Suicide Attempt

☐☐ Mania ☐☐ Panic Attacks ☐☐ Seasonal Depression ☐☐ Mood Swings

Other: _____

## Autoimmune & Inflammatory Conditions

(Mark 'P' for Past Conditions 'C' for Current Conditions)

☐☐ Hashimoto's Disease ☐☐ Colitis ☐☐ Neurodermatitis ☐☐ Rheumatism

☐☐ Crohn's Disease ☐☐ Food Allergy ☐☐ Cellulitis ☐☐ Lupus

☐☐ Atopic Dermatitis ☐☐ Sinus Infections ☐☐ Alopecia (baldness)

Other: _____

## Allergy Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

☐☐ Animal Products ☐☐ Gelatin ☐☐ Honey ☐☐ Fermented Products

☐☐ Soy ☐☐ Citrus ☐☐ Pollen ☐☐ Shellfish

Other: _____

## Sleep Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

☐☐ Can't Fall Asleep ☐☐ Restless Sleep ☐☐ Sleep Apnea ☐☐ Trouble Waking

☐☐ Excess Dreaming ☐☐ Fatigue After Eating ☐☐ Never Feel Rested ☐☐ Wakes Easily

How many hours of sleep do you get per night? _____

Other: _____

## Male Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

☐☐ Erectile Dysfunction ☐☐ Pelvic Floor Dysfunction ☐☐ Decrease Libido ☐☐ Painful Intercourse

☐☐ Prostatitis ☐☐ Sexually Transmitted Disease

Other: _____

## Female Gynecological Health

(Mark 'P' for Past Conditions 'C' for Current Conditions)

☐☐ Strong Menstrual Odor ☐☐ Vaginal Dryness ☐☐ Hot Flashes ☐☐ Irregular Menses

☐☐ Vaginal Discharge ☐☐ Fibroids ☐☐ Decreased Libido ☐☐ PMS Vaginal Odor

☐☐ Breast Lumps/Swelling ☐☐ Endometriosis ☐☐ Ovarian Cysts ☐☐ Urinary Tract Infection

☐☐ Vulvodynia ☐☐ Unexplained Pelvic Pain ☐☐ Yease Infection ☐☐ Pelvic Floor Dysfunction

☐☐ Painful Periods ☐☐ Sexually Transmitted Disease

Other: _____

☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Trying to conceive? Color of Blood _____

☐ Yes ☐ No Trouble Conceiving? ☐ Yes ☐ No Clots? Date of Last Period _____

☐ Yes ☐ No Caesarian?

_____ Age of 1st Period _____ Age at Menopause _____ # of Pregnancies

_____ # of Live Births _____ # of Premature Births _____ # of Miscarriages

_____ # of Abortions _____ # of Days Between Period _____ # of Flow Days

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Have you traveled out of the country within the past year? ☐ Yes ☐ No If so, where? _____

How's your working environment? _____

How's your home life? _____

Any additional comments or concerns? _____

The information that I have provided on this form is accurate and I will advise the practitioner of any changes in my health or changes in my medications, nutritional supplements and dietary habits.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian (patient under 18 years) Date

_____ _____

Signature of Practitioner Date