# Aspire Health Options

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## History Intake

**Name: _____ Date: _____**

**Age:_____ DOB:_____ Sex: M___ F___ Weight:_____ Height:_____**

**Allergies:** Environnemental Allergy: _____

Drug Allergy: _____

Food Allergy: _____

Allergy to Alcohol? ____YES ____NO

| **CURRENT HEALTH PROBLEMS** (List in order of importance, most important first) | Month & Year started |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

| **MAIN COMPLAINT** (please describe in some details) |
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**Are you taking immunosuppressant drugs (steroids, many arthritis drugs, etc.)?**

____YES ____NO If so, what one(s)? _____

**Are you on blood thinners or have bleeding tendencies?**

____YES ____NO If so, explain. _____

**Have you ever had a blood transfusion or organ transplant?**

____YES ____NO If so, explain. _____

**Do you have a pacemaker or hearing aids?**

____YES ____NO If so, which one? _____

**Are you on birth control (pill, IUD – copper or plastic, implant, patch, ring, shot, etc.)?**

____YES ____NO If so, what type? _____

**Have you ever had a hysterectomy (full or partial)?**

____YES ____NO If so, which type? _____

**Do you have any fillings in your teeth (amalgam, gold, porcelain, composite, resin or glass ionomer)?**

____YES ____NO If so, what type? _____

**Do you have any artificial body parts/reparative devices (stents, screws, wire, knees, hips, breast augmentation, teeth implants, mesh, metal plates, etc.)?**

____YES ____NO If so, what type? _____

**Have you ever had a Barium enema or a Barium drink for medical testing purposes?**

____YES ____NO If so, explain. _____

**Have you ever been diagnosed with diabetes (pre, type 1 or 2, GDM, or diabetes insipidus)?**

____YES ____NO If so, what type? _____

**Have you had any concussions?**

____YES ____NO If so, how many and approximate dates? _____

**Do you suffer with any addictions?**

____YES ____NO

**Do you currently or have you ever used any of the following: Tobacco (chew/cigarette), cigar, marijuana, etc.?**

____YES ____NO If so, what type? _____

**Did you have typical childhood vaccines?**

____YES ____NO

**How often do you get/have you had flu vaccines?**

____NEVER ____RARELY ____EVERY FEW YEARS ____YEARLY

**Have you had any other vaccine boosters in the last 10-15 years (pneumococcal, Tdap, chicken pox, shingles, Hepatitis, others)?**

____YES ____NO If so, which one(s)? _____

| Symptoms | Frequency | | | | | Severity | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Highlight or Star (*)** the five symptoms that bother you most.<br><br>**Severity:** 1 = mild / 5 = severe & intolerable<br><br>Please note: SOME LINES HAVE MULTIPLE SYMPTOMS. PLEASE MAKE CLEAR WHICH ONE(S) APPLY TO YOU ON THAT LINE by underlining, **Bolding**, or circling. | DAILY | FEW DAYS/WEEK | OCCASIONALLY | RARELY | PAST SYMPTOM | 1 | 2 | 3 | 4 | 5 |
| **Head, Face, Neck** | | | | | | | | | | |
| • Unexplained hair loss | | | | | | | | | | |
| • Headache, mild or severe, seizures | | | | | | | | | | |
| • Migraine, migraine with aura | | | | | | | | | | |
| • Pressure in head, white matter lesions in brain (MRI) | | | | | | | | | | |
| • Twitching of facial or other muscles | | | | | | | | | | |
| • Facial paralysis (Bell's Palsy, Horner's syndrome) | | | | | | | | | | |
| • Tingling of nose, (tip of) tongue, cheek or facial flushing | | | | | | | | | | |
| • Stiff or painful neck | | | | | | | | | | |
| • Jaw pain or stiffness | | | | | | | | | | |
| • Dental problems | | | | | | | | | | |
| • Sore throat, clearing throat, phlegm, or hoarseness | | | | | | | | | | |
| • Runny nose or Sinus issues | | | | | | | | | | |
| • Dry eyes, dry mouth | | | | | | | | | | |
| | | | | | | | | | | |
| **Eyes/Vision** | | | | | | | | | | |
| • Double or blurry vision | | | | | | | | | | |
| • Increased floating spots | | | | | | | | | | |
| • Pain in eyes, or swelling around eyes | | | | | | | | | | |
| • Oversensitivity to light | | | | | | | | | | |
| • Flashing lights, peripheral waves, phantom images in corner of eyes | | | | | | | | | | |
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| **Ears/Hearing** | | | | | | | | | | |
| • Decreased hearing in one or both ears, plugged ears | | | | | | | | | | |
| • Buzzing in ears or Ringing in one or both ears | | | | | | | | | | |
| • Pain in ears, oversensitivity to sounds | | | | | | | | | | |
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| **Musculoskeletal System** | | | | | | | | | | |
| • Bone or back pain, joint pain or swelling, carpal tunnel | | | | | | | | | | |
| • Stiffness of joints, back, neck, tennis elbow | | | | | | | | | | |
| • Muscle pain or cramps, (Fibromyalgia) | | | | | | | | | | |
| • Gout | | | | | | | | | | |

| Symptoms | Frequency | | | | | Severity | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
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| **Integument (Skin) System** | | | | | | | | | | |
| • Rash, bullseye or other | | | | | | | | | | |
| • Unexplained Hives | | | | | | | | | | |
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| **Digestive and Excretory Systems** | | | | | | | | | | |
| • Diarrhea | | | | | | | | | | |
| • Constipation | | | | | | | | | | |
| • Hemorrhoids | | | | | | | | | | |
| • Irritable bladder (trouble starting, stopping), interstitial cystitis, or UTI-like symptoms | | | | | | | | | | |
| • Irritable bowel (IBS), intestinal cramping, bloating | | | | | | | | | | |
| • Upset stomach (nausea or pain) or GERD/acid reflux | | | | | | | | | | |
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| **Respiratory and Circulatory Systems** | | | | | | | | | | |
| • Shortness of breath, can't get full/satisfying breath | | | | | | | | | | |
| • Asthma | | | | | | | | | | |
| • Cough | | | | | | | | | | |
| • Chest pain or rib soreness | | | | | | | | | | |
| • Night sweats or unexplained chills | | | | | | | | | | |
| • Heart palpitations or extra beats | | | | | | | | | | |
| • High Blood Pressure or Low Blood Pressure | | | | | | | | | | |
| • Endocarditis, heart blockage | | | | | | | | | | |
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| **Neurologic System** | | | | | | | | | | |
| • Tremors or unexplained shaking | | | | | | | | | | |
| • Burning or stabbing sensations in the body | | | | | | | | | | |
| • Fatigue, Chronic Fatigue Syndrome | | | | | | | | | | |
| • Peripheral neuropathy or partial paralysis | | | | | | | | | | |
| • Weakness or loss of strength in hands or legs | | | | | | | | | | |
| • Pressure in the head | | | | | | | | | | |
| • Numbness in body, tingling, pinpricks | | | | | | | | | | |
| • Restless legs | | | | | | | | | | |
| • Poor balance, dizziness, difficulty walking | | | | | | | | | | |
| • Increased motion sickness | | | | | | | | | | |
| • Light-headedness, wooziness | | | | | | | | | | |

| Symptoms | Frequency | | | | | Severity | | | | |
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| **Psychological Well-being** | | | | | | | | | | |
| • Mood swings, irritability, bi-polar disorder | | | | | | | | | | |
| • Unusual depression | | | | | | | | | | |
| • Disorientation (getting or feeling lost) | | | | | | | | | | |
| • Feeling as if you are losing your mind | | | | | | | | | | |
| • Over-emotional reactions, crying easily | | | | | | | | | | |
| • Too much sleep, or insomnia | | | | | | | | | | |
| • Difficulty falling or staying asleep | | | | | | | | | | |
| • Narcolepsy, sleep apnea | | | | | | | | | | |
| • Panic attacks, anxiety, PTSD | | | | | | | | | | |
| • OCD, ADD, ADHD | | | | | | | | | | |
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| **Mental Capability** | | | | | | | | | | |
| • Memory loss (short or long term) | | | | | | | | | | |
| • Confusion, difficulty thinking | | | | | | | | | | |
| • Difficulty with concentration | | | | | | | | | | |
| • Difficulty with reading | | | | | | | | | | |
| • Going to the wrong place | | | | | | | | | | |
| • Speech difficulty (slurred or slow) | | | | | | | | | | |
| • Difficulty finding commonly used words | | | | | | | | | | |
| • Stammering speech | | | | | | | | | | |
| • Forgetting how to perform simple tasks | | | | | | | | | | |
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| **Reproduction and Sexuality** | | | | | | | | | | |
| • Loss of sex drive | | | | | | | | | | |
| • Sexual dysfunction | | | | | | | | | | |
| • Unexplained menstrual pain, irregularity | | | | | | | | | | |
| • Unexplained breast pain, discharge | | | | | | | | | | |
| • Yeast Infections | | | | | | | | | | |
| • Testicular or pelvic pain | | | | | | | | | | |

| Symptoms | Frequency | | | | | Severity | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
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| **General Well-being** | | | | | | | | | | |
| • Phantom smells | | | | | | | | | | |
| • Unexplained weight gain or loss | | | | | | | | | | |
| • Extreme fatigue | | | | | | | | | | |
| • Swollen glands or lymph nodes | | | | | | | | | | |
| • Unexplained fevers (high or low grade) | | | | | | | | | | |
| • Continual infections (sinus, kidney, eye, etc.) | | | | | | | | | | |
| • Symptoms seem to change, come and go | | | | | | | | | | |
| • Pain migrates (moves) to different body parts | | | | | | | | | | |
| • Low body temperature | | | | | | | | | | |
| • Allergies or chemical sensitivities | | | | | | | | | | |
| • Increased effect from alcohol and possible worse hangover | | | | | | | | | | |
| • Early on, experienced a "flu-like" illness, after which you have not felt well. If yes, mark "past symptom" and severity) | | | | | | | | | | |
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| **Additional Symptoms** | | | | | | | | | | |
| • Psoriasis | | | | | | | | | | |
| • Vitiligo | | | | | | | | | | |
| • Warts | | | | | | | | | | |
| • Dry skin, dandruff | | | | | | | | | | |
| • Dark circles under eyes | | | | | | | | | | |
| • Negative reactions to vaccines | | | | | | | | | | |
| • Flatulence | | | | | | | | | | |
| • Poor skin integrity | | | | | | | | | | |
| • Excessive snoring | | | | | | | | | | |
| • Brittle nails | | | | | | | | | | |
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| **Other** | | | | | | | | | | |
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**If complaining of pain, how do you describe your pain?**

**Does the pain refer or radiate to other places? Does it change or come and go?** Please explain

**What factors worsen your pain?**

**What factors decrease your pain?**

**Is your pain resulting from an accident?**

____YES ____NO If so, explain. _____

| **Diagnoses received to date:** |
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List investigations done so far and their results:

- ☐ MRI
- ☐ CT Scan
- ☐ X-Ray
- ☐ Endoscopy
- ☐ Other: _____

| **Treatment received up-to-date for your current problem(s):** |
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| **List all *CURRENT* medications and supplements:** |
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| **List all *PAST* medications and supplements:** |
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**Check or highlight all treatment received in the past or being currently received:**

- ☐ Bed rest
- ☐ Traction
- ☐ Nerve blocks
- ☐ Exercise
- ☐ Hypnosis
- ☐ Chiropractor
- ☐ Pharmaceuticals
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Electrical stimulation
- ☐ Surgery
- ☐ Acupuncture
- ☐ Epidural blocks
- ☐ Heat treatment
- ☐ Physical Therapy
- ☐ Supplements
- ☐ Other

| **List of all Surgical Operations** | **Year Performed** |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |

| **List of Cancer Diagnoses and Treatments** | **Year Diagnosed** |
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| **Other States and Countries *Traveled To* (Important)** | **Approximate Dates of Travel (year )** |
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| **Other State and Countries *Lived In* (Important)** | **Years** |
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**<u>Daily Habits</u> (E.g. walking/exercising; smoking; daily alcoholic drink, coffee, soda; computer; TV, etc.)**

**<u>Past & Present Hobbies</u> Please list all you can think of. This information is used to determine exposure. (E.g. fishing, hunting, stained glass, painting, reading, gardening, welding, building things, auto repair, etc.)**

**<u>Family History of Illnesses</u> (Please *also* indicate where family member lived just before/during illness)**

**Are you (or have you ever been) on well water?** ____YES ____NO

**Do you live under or very close to high voltage power lines?** ____YES ____NO

**Do you or have you ever lived near a nuclear power plant/radiation zone?** ____YES ____NO

**Do you have or have you ever had pets?**

____YES ____NO **If so, what type?** _____

_____

**Have you ever been bitten by a tick that you are aware of?**

____YES ____NO **If so, where were you (State/Country) when this occurred and what was the approximate year? _____**

| **Employment - *Where you worked and what you did*. (Important) This helps determine potential exposure to toxins, pathogens, etc.** | **Approximate Dates by Year** |
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**Thank you! I know this is long, but it will save time on exam day and will assist in a more thorough exam.**