HEALTH INVENTORY

NAME_____ DATE_____/_____/_____

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

__Weakness
__Palpitation
__Depression
__Crying Easily
__Indecisiveness
__Irritability
__Personality Changes
__Tiring Easily
__Numbness
__Shaky Hands
__Lack of Interest
__Anxiety
__Family Problems
__Seeing Thing
__Paranoia
__Low Self-esteem
__Nightmares
__Dry Mouth
__Short tempered
__Suicidal Feelings
__Feelings of Hopelessness
__Feelings of Guilt
__Feelings of Inferiority
__Hearing Voices
__Poor Attention Span
__Inability to Relax
__Socially Withdrawn
__Physical Complaints
__Racing Heart
__Constant Worry

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

__Weakness
__Tension Headache
__Migraine Headache
__TMJ Disorder
__Chronic Back Pain
__Chest Pain or Angina
__Abdominal Pain
__Pelvic or Genital Pain
__Arthritis
__Bone Fracture
__Concussion
__Thyroid Disorder
__Lack of Interest
__Heart Attack or Heart Disorder
__Lung or Respiratory Disease
__Liver Disease or Hepatitis
__Kidney Disorder or Kidney Stones
__Urinary or Bladder Disorder
__Skin Disorder, Eczema, Hives
__High Blood Pressure
__Low Blood Pressure
__Sexually Transmitted Disease
__Pre-Menstrual Syndrome or Menstrual Changes
__Prostate or Vaginal Disorder
__Feelings of Hopelessness
__Epilepsy
__Cancer
__Insomnia
__Asthma
__Allergies
__Peptic Ulcer
__Colitis
__Diabetes
__Hypoglycemia
__Deafness
__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____/____/____

__Cold Hands or Feet
__Swollen Ankles or Feet
__Stiff, Aching Joints
__Neck or Shoulder Tension
__Grinding Your Teeth
__Ringing in Ears
__Rapid Heartbeat
__Short-term Memory Loss
__Excessive Sweating
__Difficulty Sleeping
__Overeating or Binge Eating
__Under eating or Poor Appetite
__Job Dissatisfaction
__Sex Life Not Satisfying
__Lack of Fun or Affection
__Long-term Memory Loss
__Colds or Flu
__Sore Throat
__Dizziness
__Diarrhea
__Constipation
__Nausea, Vomiting
__Hyperventilation
__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?

__Ice Cream __Glass of Beer or Wine __Can of Soda Pop __Cigarette
__Cup of Coffee __Liquor or Cocktail __Recreational Drug __Chocolate

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

__Aspirin or Pain Reliever __Sleeping Pill __Antidepressant __Lithium
__Pain Relieving Drug __Tranquilizer __Blood Pressure Medication __Anti-anxiety

Please list all medications that you are taking: Please include all herbal remedies and any dietary supplements:	Dose (how much? How often?)	How taken? (pills, liquid, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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