Big Sky Wellness Center
PO Box 1090
Paulden, AZ 86334
928-260-4747 (office)
928-447-7988 (fax)

PATIENT HEALTH HISTORY

Date: ___________

Name: ____

Physical Address: ______________________________ Occupation: _____________________

City: ______________________State:_____ Zip: _________ Employer: ______________________

Mailing Address: _______________________________

City: ________________________State:____ Zip: _________

Home Phone #: ___________________ E-Mail: _________________________________

Cell Phone #: _____________________ Social Security #: _______________________

Date of Birth: __________ Age: _____ Sex: □Male □Female Weight: ________ Height: _________

Marital Status: □Married □Single □Divorced □Separated □Other___________

Name of Spouse or Nearest Relative: ________________________ Phone: ___________________

Referred by: ______________________ May we thank them for the referral? □Yes □No

Please list below the top 3 main reasons for your appointment, in order of importance.

- **Please tell me about it in as much detail as possible.**
- **Please list the very first time that you noticed the condition.**

1.

2.

3.

If you were to guess, what do you think is the cause of your complaints?

What other healthcare providers have you seen regarding this problem(s)?

What diagnosis were you given?

Date of last physical examination: ________________________________

Date of last blood work and results: _______________________________

Do you suffer from any condition other than that for which you are now consulting us? □Yes □No _____________

Please list any operations or surgeries:

□ I have never had any operations or surgeries

Current medications (prescription or over-the-counter):	For what purpose are you taking these medications?
If you are taking NO prescription or over-the-counter medications (Ibuprofen, Aleve, Prilosec, etc.) Please check here: □	
____	____
____	____
____	____
____	____

Current Supplements:	For what purpose are you taking these supplements?
____	____
____	____
____	____
____	____
____	____

Eating Style: Based on how you eat on a regular basis, please circle all that apply:

Fast eater	Family member(s) have different tastes
Erratic eater	Love to eat
Emotional eater (stressed, board, sad, etc.)	Eat too much
Late night eater	Eat because I have to
Time constraints	Negative relationship with food
Dislike “heatlhy” food	Struggle with eating issues
Travel frequently	Confused about food/nutrition
Do not plan meals/menus	Frequently eat fast food
Rely on convenience items	Poor snack choices

If you do, how much time do you spend cooking/preparing meals each day?___________________________________

List any foods that you crave or would have a difficult time living without: ______________________________________
(e.g. coffee, donuts, chocolate, cheese)

Specific Food Restriction:
□ Dairy
□ Wheat
□ Eggs
□ Soy
□ Corn
□ All gluten
□ Other: ______________

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work_______Family_______Social_______Financial_______Health_______Other_______

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	**1**	**2**	**3**	**4**	**5**
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

What have you tried to do to improve your state of health?
□ Diet modification □ Fasting □ Vitamins/minerals □ Herbs
□ Homeopathy □ Chiropractic □ Acupuncture □ Conventional Drugs
□ Other: ____

Is your general health currently getting better, worse, or staying the same. How do you know?

How long do you feel this will take?

Do you believe there is a solution to your health concerns?

Do you believe you can be 100% healthy and pain-free?

What percent of improvement in your symptoms do you expect to notice?

Patient's/Guardian's Signature:_________________________________ Date: _______________