# River City Wellness

Health History Paperwork

**Welcome to River City Wellness:** It is my goal to help each and every patient improve their quality of life and achieve optimum health. In order to provide you with the most effective care possible, I encourage you to fill out the paperwork in detail and as accurately as possible. All symptoms you experience are relevant and make up a complete picture of your health physically, emotionally and mentally. Thank you.

## Personal Information

Name: _____ Date of Birth: _____/_____/_____

Address:_____ City:_____ Zip:_____

Phone #: _____ Email: _____

How did you hear about River City Wellness: _____

Primary Care Provider:_____

Please list all medications, herbs, vitamins or supplements you currently take:_____

_____

## General Health Information

Main Health Complaints — How are you affected?

1. _____ _____

2. _____ _____

3. _____ _____

Any medical diagnosis? _____

Any secondary health complaints: _____

_____

Do you have an infectious disease? Yes No If yes, please identify:_____

## History of Illness, Trauma, Surgery or Accident (please list age and any hospitalizations):

Childhood: _____

_____

Adolescence: _____

_____

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Adulthood: _____

_____

_____

Do you have any scars? If yes, please note location and reason: _____

_____

**Medical Conditions** (Please circle all that apply to you):

*Per the state of Kentucky, items indicated with asterisk require the care of a primary physician

| | | | |
|---|---|---|---|
| Diabetes* | Heart Disease* | Acute Respiratory Distress* | Autoimmune |
| Hypertension* | Cancer* | Undiagnosed Neurological changes* | HIV |
| Thyroid disorder | Tuberculosis | Unexpected Weight loss* | Mood disorder |
| Hepatitis | Suspected fracture* | Bleeding or hemorrhage* | Mental illness |
| Acute Severe Abdominal Pain* | | Suspected Systematic infection* | Anemia |

**Lifestyle**

- Do you typically eat at least 3 meals per day? Y N If no, how many?_____
- Do you feel you need help on eating healthier? Y N
- Do you have any food cravings? _____
- Carbonated drinks: _____/day Glasses of water: _____/day Cups of caffeine: _____/day
- Alcohol drinks: _____/day or week Do you use nicotine: Y N If yes, how much: _____/day
- Average hours of sleep per night: _____ Do you wake rested? Y N

  Dreams/Nightmares Trouble falling asleep Trouble staying asleep
- Occupation: _____ #Hours/Week: _____

  Do you enjoy work? Y N Why/Why not? _____
- Do you feel stressed? Y N What creates stress in your life? _____

  Have you been through a period of continual stress? If so, when, why and for how long? _____

  _____

  _____
- Interests/hobbies: _____

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Endocrine System (Kidney Organ System)

- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Feeling hot or cold
- ☐ Cold hands or feet
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Fatigue
- ☐ Infertility
- ☐ Menstrual Irregularities

Respiratory (Lung and Kidney System)

- ☐ Pneumonia
- ☐ Frequent colds
- ☐ Persistent cough
- ☐ Sneezing
- ☐ Allergies
- ☐ Asthma
- ☐ Fatigue
- ☐ Sinus congestion
- ☐ Bronchitis
- ☐ Sore throats
- ☐ Skin conditions
- ☐ Post nasal drip
- ☐ Difficulty Breathing
- ☐ Shortness of Breath

If you are a smoker, # of cigarettes per day _____ Years smoked _____ Do you want to quit? Y N

Head, Eyes, ENT (Blood function and Liver, Heart and Spleen Systems)

- ☐ Blurry vision
- ☐ Eye pain/strain
- ☐ Glaucoma
- ☐ Glasses/contacts
- ☐ Tearing/dryness
- ☐ Floaters
- ☐ Dizziness
- ☐ Earaches
- ☐ Tinnitus
- ☐ Sinus problems
- ☐ Congestion
- ☐ Post nasal drip
- ☐ Teeth grinding
- ☐ TMJ
- ☐ Headaches
- ☐ Poor memory
- ☐ Poor concentration

Cardiovascular (Heart System)

- ☐ Heart disease
- ☐ Chest pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Heart murmur
- ☐ Shortness of breath
- ☐ Varicose veins
- ☐ Arrhythmia
- ☐ Tachycardia
- ☐ Anemia
- ☐ Anxiety
- ☐ Cold hands/feet
- ☐ Depression
- ☐ Forgetfulness
- ☐ Tongue ulcers
- ☐ Insomnia
- ☐ Vivid dreaming
- ☐ Ankle swelling
- ☐ High blood pressure
- ☐ Low blood pressure

Gastrointestinal (Spleen and Stomach Systems)

- ☐ Stomach ulcers
- ☐ Strong appetite
- ☐ Weak appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Heartburn/reflux
- ☐ Belching
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Noisy intestines
- ☐ Bruise easily
- ☐ Hemorrhoids
- ☐ Atherosclerosis
- ☐ Stomach ache
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Fatigue after meals
- ☐ Food cravings

Elimination Function (Intestine Systmes)

- ☐ Constipation
- ☐ Effort to eliminate
- ☐ Incomplete stools
- ☐ Diarrhea
- ☐ IBS
- ☐ Polyps
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Frequent UTI
- ☐ Kidney disease
- ☐ Painful urination
- ☐ Impaired urination
- ☐ Blood in urine
- ☐ Kidney stones

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Please CHECK any symptoms that you have now and UNDERLINE any you have experienced in the past.

Neurological

- ☐ Vertigo/Dizziness
- ☐ Numbness
- ☐ Loss of Balance
- ☐ Paralysis
- ☐ Tingling
- ☐ Seizures

Autoimmune and Inflammatory Conditions

- ☐ Hashimoto's
- ☐ Allergy
- ☐ Endometriosis
- ☐ Multiple sclerosis
- ☐ Rheumatism
- ☐ Food allergy
- ☐ Chronic fatigue
- ☐ Psoriasis
- ☐ Lupus
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Eczema
- ☐ Colitis
- ☐ Tendonitis
- ☐ Celiac's
- ☐ Crohn's
- ☐ Lyme
- ☐ Interstitial cystitis

Female Reproductive

- ☐ Irregular cycles
- ☐ PMS
- ☐ Emotional reactions
- ☐ Low libido
- ☐ Breast tenderness
- ☐ Clotting
- ☐ Menopause
- ☐ Heavy flow
- ☐ Cramping
- ☐ Infertility

Do you have any reason to believe you are pregnant? Y N If so, how far along are you? _____

Age of first menses: _____ Length of cycle: _____days Length of menses _____days

# of pregnancies: _____ # of miscarriages: _____ # of live births: _____

Birth control type: _____

Male Reproductive

- ☐ Sexual difficulties
- ☐ Testicular pain
- ☐ Infertility
- ☐ Prostate problems
- ☐ Discharge

Musclo-skeletal (Liver, Kidney and Spleen systems)

- ☐ Pain - Where in the body (list joints or areas effected): _____

  _____
- ☐ Tendonitis/ Arthritis – joints effected: _____
- ☐ General tension – Where: _____
- ☐ Muscle spasms / cramps – Where: _____
- ☐ Weakness in the body – Where: _____
- ☐ Spine problems – please list: _____

31012 Eastpoint Parkway, Louisville, KY 40223 Email: rivercitywellnessacu@gmail.com

www.rivercitywellnessacu.com