Fenske Holistic Healthcare Center (608) 836-8883

Patient Health History

Laser Therapy patients

Name____ **Date**________________

Date of Birth ____________________ **Age** ________ **Height** ________ **Weight** ___________

Occupation _____________________________________

Race/Ethnicity(circle one): **White/Caucasian Black/African Amer. Asian Hispanic/Spanish Native Hawaiian Amer. Indian**

What brings you to our office?____

List your major health problems/concerns:

1. ____

____

2. ____

____

3. ____

____

Describe the causes of these concerns (if known or suspected): _____________________________

____

____

____

Have you had the same (or similar) problem before *(circle one)*? **Y / N**

What activities aggravate your problem(s)? ____

____

What activities improve your problem(s)? ____

____

Are your problems getting progressively worse? **Y / N**

Are your problems interfering with *(check all that apply)*:

☐ Work ☐ Daily Routine ☐ Sleep ☐ Other ____________

If your condition involves pain please characterize type:

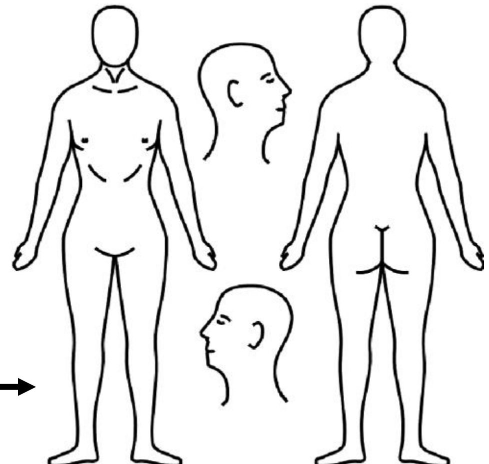
☐ Ache ☐ Sharp ☐ Radiating ☐ Constant ☐ Intermittent

Please rate the amount of pain you are generally experiencing:

(circle one) mild 1 2 3 4 5 6 7 8 9 10 severe

Please use the diagram to the right to indicate areas of involvement →

(mark: **P** *for pain,* **T** *for tightness,* **N** *for numbness).*



Previous Treatment for Health Problems

Were you previously treated for the above problems? **Y / N**

*(if no, skip to **Health Maintenance Update** section below)*

Name of practitioner ____

Date first seen____________________________ Date last seen_____________________________

Condition or diagnosis____

How was the condition treated____

Results of treatment: ☐ Good ☐ Fair ☐ Poor

Please list below other practitioners seen for this condition: (or check here for none ____)

Name Date (approx.) Testing/Treatment

1. ____
2. ____
3. ____
4. ____

Additional remarks about previous treatment ____

____

Current primary care physician ____

Do you suffer from any other health problems from which you are not seeking consultation with us?

Y / N If yes, please itemize below:

Condition Date of onset (approx.) Practitioner

1. ____
2. ____
3. ____

Health Maintenance Update

Please indicate approximate dates and results of last:

Physical exam ____

Spinal exam ____

Dental exam ____

Cholesterol profile ____

Other blood tests ____

Chest X-ray ____

Spinal X-ray ____

Bone density (DEXA) scan ____

Mammogram ____

Eye exam ____

Colonoscopy or flexible sigmoidoscopy ____

Other ____

List all medications you are currently using, or have used recently. Include all over-the-counter medications. List dosages and approximate length of time you have used each medication:

____
____
____
____
____

List (include name, brand, dosage) all vitamins, minerals, herbs, and other natural products you are currently using:

____
____
____
____
____
____
____

List medication/supplement/environmental allergies or intolerances and associated reactions:

____
____
____
____
____