GROWTH AND HEALING
WELLNESS CENTER, LLC

HEALTH HISTORY CHECKLIST

NAME: _____ DATE: _____

PRIMARY CARE DOCTOR: _____ DATE OF LAST PHYSICAL: _____

CITY/STATE/ZIP: _____ TELEPHONE: _____

INJURIES or ILLNESSES: _____

IF PRESENT, CIRCLE NUMBERS and SYMPTOMS THAT APPLY TO YOU:

1. Severe PMS symptoms: *Cramping, Bleeding, Headaches, Nausea, Vomiting, Mood Swings, Hot Flashes*
2. Allergies: *Environmental:* _____ *Food:* _____
3. Fatigue/Exhaustion: *When:* _____
4. Mind Races: *Can't Stop Thinking, Obsessive Thinking, Worrying*
5. Insomnia: *Can't Get To Sleep, Interrupted Sleep, Early Morning Waking*
   How Many Hours Of Sleep Do You Get Each Night? _____
6. Mood Swings: *Feel High Then Low, Angry Outbursts, Feel Out Of Control*
   How Often? _____
7. Depression: *Difficulty Getting Out Of Bed, Unhappy Most Of The Time, Unable To Concentrate, Do Not Enjoy Things I Used To Enjoy, Suicidal Thought, Suicidal Gestures*
   *When did it begin?*_____
8. Headaches or Migraines: *Where: Forehead, Temples, Back Of Neck, Face, Sinuses, One Side Of Face*
   How Often? _____
9. Crying: *Supersensitive, Weepy, Breaking Out In Tears Unexpectedly*
10. Perspiration: *Where: Feet, Underarms, Night Sweats, Sweaty Palms*
11. Eating issues: *Use Of Laxatives, Fear Of Getting Fat, Purging Vomiting, Excessive Dieting, Unhealthy Cravings*
12. Pain in Joints: *Knees, Elbows, Fingers, Other:* _____
13. Poor Circulation *Cold Hands Or Feet, Light Headiness, Dizzy Spells*
14. Excessive Worry: *Panicky, Paranoia, Escalating Fears, Rumination*
15. Anxiety: *Stressed Out, Hyperactive, Generalized Anxiety*

16	Panic Attacks:	*Racing Heart, Pounding Heart, Pain In Chest, Tightness In Chest, Sinking Feelings*
17	Weight gain or loss in	*Loss _____Lbs Gain _____Lbs* *Date Began: _____*
18	Poor concentration:	*Short Term Memory and/or Long Term Memory*
19	Short attention span:	*Spaciness Or Dissociation*
20	Skin Problems:	_____
21	Yeast Infection/UTI:	*How Often: _____*
22	Poor Digestion:	*Heartburn, Ulcers, Burning Or Burping, Gassy, Bloating*
23	Aching Muscles:	*Muscle Cramps, Spasms In Legs*
24	Hypoglycemia or diabetes:	*On Insulin, Special Diet*
25	Problems with anger management:	*Physical and/or Verbal Abuse Of Others*
26	Neck Pain or Tension	
27	Lower Back Pain or Tension	
28	Physical abnormalities of any kind:	_____
29	Traumatic physical injuries:	*When: _____ Where: _____*
30	Eyesight or hearing loss	
31	Constipation or diarrhea:	*How often?_____*