Name: **Date:**

Henke Health
1304 S. College Ave., Suite No. 5
Fort Collins, CO 80524
tel: 970-482-0549 fax: 970-493-1192

Social history

Relationships ☐ Single
☐ Married/committed relationship

Employed outside the home? ☐ Yes ☐ No

What area of work?

Is your job enjoyable and fulfilling? ☐ Yes ☐ No ☐ Sometimes

Exercise and Body Care

Do you stretch, yoga, get a massage, chiropractic care, acupuncture, etc.?

What do you like to do for exercise, how often and for how long?

Do you take time for meditation, prayer or reflection ☐ Yes ☐ No

If yes, how long and how often

Do you observe a day of rest completely away from work dedicated to nurturing yourself and your family ☐ Yes ☐ No

What do you like to do to relax

Who is your biggest emotional support

Indoor pets ☐ Yes ☐ No

Do you use pesticides in your home or have your home treated for insects ☐ Yes ☐ No

Habits

Tobacco use ☐ Yes ☐ No

Exposed to tobacco smoke ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

Year quit?

Do you use a seatbelt ☐ Yes ☐ No

Wear a helmet if appropriate for activity ☐ Yes ☐ No

Drinking Water-- Amount and type/day

Drink soda? ☐ Yes ☐ No

If yes, what type and how many per day

How much time on a cell phone/computer per day.

Other sources of EMFs. ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

If yes, type and amount/week

Caffeine ☐ Yes ☐ No

If yes, how much

Shower water--Is it chlorine free ☐ Yes ☐ No

Use of microwave ☐ Yes ☐ No

If yes, do you use plastic in it ☐ Yes ☐ No

Awareness of toxin exposure at home and/or work ☐ Yes ☐ No

Review of Systems

General

Do you consider yourself under weight, overweight or just right.

Weight changes in the last six months ☐ Yes ☐ No

Stress level 0 – 10 (10 being very high)

What is your biggest area of stress?

Compulsive/binge eating/drinking ☐ Yes ☐ No

Frequently ill? ☐ Yes ☐ No

Neurological/Emotional

Fatigue/sluggish ☐ Yes ☐ No

Hyperactive ☐ Yes ☐ No

Mood swings ☐ Yes ☐ No

Angry/irritable ☐ Yes ☐ No

Easily startled ☐ Yes ☐ No

Anxious/nervous ☐ Yes ☐ No

Poor memory ☐ Yes ☐ No

Learning disabilities ☐ Yes ☐ No

Difficult time making decisions ☐ Yes ☐ No

Poor concentration ☐ Yes ☐ No

Poor coordination ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Over the past two weeks, how often have you been bothered by little interest or pleasure in doing things: ☐ not at all ☐ several days ☐ more than half the days ☐ nearly every day

Over the past two weeks, how often have you been bothered by feelings of being down, depressed or hopeless: ☐ not at all ☐ several days ☐ more than half the days ☐ nearly every day

Do you develop symptoms with exposure to fragrances, exhaust fumes or other strong odors? ☐ Yes ☐ No

Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides or organic solvents? ☐ Yes ☐ No

Sleep

Time to bed

Time awaken

Fall asleep easily ☐ Yes ☐ No

Insomnia ☐ Yes ☐ No

Move/jerk while sleeping ☐ Yes ☐ No

Use sleep aids ☐ Yes ☐ No

Snore regularly ☐ Yes ☐ No

Wake up feeling refreshed ☐ Yes ☐ No

Head, Eyes, Ears, Nose

Problems with hearing ☐ Yes ☐ No

Ear drainage ☐ Yes ☐ No

Ringing in ears ☐ Yes ☐ No

Approximate date of last eye checkup

Visual problems ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Dizziness ☐ Yes ☐ No

Hay fever ☐ Yes ☐ No

Sinus problems ☐ Yes ☐ No

Can you breathe through your nose ☐ Yes ☐ No

Tonsils present ☐ Yes ☐ No

Neck

Trouble swallowing ☐ Yes ☐ No

Stiffness ☐ Yes ☐ No

Lumps/fullness ☐ Yes ☐ No

Tolerate heat ☐ Yes ☐ No

Tolerate cold ☐ Yes ☐ No

Tongue problems ☐ Yes ☐ No

Oral

Problems with teeth and mouth (examples; frequent canker sores, tongue problems):

Lungs

Cough	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Frequent throat clearing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Heart

Irregular heart rhythm	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Do you know your approximate cholesterol levels		
History of anemia	☐ Yes	☐ No

Kidneys

History of kidney stones	☐ Yes	☐ No
Frequent bladder/kidney infections	☐ Yes	☐ No

Digestive System

Bloated Feeling	☐ Yes	☐ No
Frequency of BMs		
Characteristic of stool (example loose, hard)		
Color		
Black stools	☐ Yes	☐ No
Heartburn/Indigestion	☐ Yes	☐ No
Pass gas frequently	☐ Yes	☐ No
If yes, strong odor	☐ Yes	☐ No
Ever had any type of colon cancer screening	☐ Yes	☐ No
If yes, type and when		

Female System

Last menstrual period		
Interval of time between cycles	days	
Length of cycle	days	
Cycle regular	☐ Yes	☐ No
Spotting between cycles	☐ Yes	☐ No
Birth control used	☐ Yes	☐ No
If yes, type		
Ever pregnant	☐ Yes	☐ No
If yes, how many times		
Date of last Pap and results		
Any history of abnormal paps	☐ Yes	☐ No
Recurrent yeast infection	☐ Yes	☐ No
Fibrocystic breast changes	☐ Yes	☐ No
PMS symptoms	☐ Yes	☐ No
Satisfied with sexual functioning	☐ Yes	☐ No
Satisfied with sexual drive	☐ Yes	☐ No
Difficulty/pain with urination	☐ Yes	☐ No
Loss of urine with cough or sneezing	☐ Yes	☐ No
Little time to get to the bathroom	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Previous mammogram	☐ Yes	☐ No
If yes, date and results		
Ever had breast thermography	☐ Yes	☐ No

Male system

- Up at night to urinate ☐ Yes ☐ No
- If yes, how often
- Blood in urine ☐ Yes ☐ No
- Penile Discharge ☐ Yes ☐ No
- Jock itch ☐ Yes ☐ No
- Last prostate check if age over 40
- Satisfied with sexual functioning ☐ Yes ☐ No
- Satisfied with sexual desire ☐ Yes ☐ No

Extremities (legs, arms, hands and feet)

- Pain ☐ Yes ☐ No
- If yes, where
- Stiffness ☐ Yes ☐ No
- Weakness ☐ Yes ☐ No
- Numbness/ tingling ☐ Yes ☐ No

Back

- Pain ☐ Yes ☐ No
- If yes, at what level and intensity

Skin

- Acne ☐ Yes ☐ No
- Too dry ☐ Yes ☐ No
- Skin tags ☐ Yes ☐ No
- Hair thinning/loss ☐ Yes ☐ No
- Rash ☐ Yes ☐ No
- Suspicious moles ☐ Yes ☐ No
- Excessive sweating ☐ Yes ☐ No
- Hot flashes ☐ Yes ☐ No

Diet

- Time of first meal in the morning
- Typical breakfast
- Time of second meal
- Type of foods
- Time of third meal
- Types of food
- Do you have more meals/snacks in a normal day
- How often do you eat a dessert/week
- Avoid any foods ☐ Yes ☐ No
- Are there any foods you love to eat every day ☐ Yes ☐ No
- If yes, what are they
- Consume high fructose corn syrup ☐ Yes ☐ No

Medical history: (examples: asthma, childhood ear infections, high blood pressure)

Surgical history: (examples: removal of tonsils, hip replacement)

Dental history: (examples: fillings and type, crowns, root canals)

Allergies: (medications and food)

Medications And Supplement List: (Please list prescription medicines first)

Name of Medication or Supplement	Dosage	Amount		Date Started
Ex. Benadryl	25mg	1 every 6 hours		May 2012

Family history: (examples: cancer, heart disease, thyroid problems, depression, etc)