Dr. Nate Greenstein
Patient Health History (1 of 2)

Please complete both pages of the health history form. Be as complete and accurate as possible. If something does not apply, record the word **"none"** for that item. ***Please print or type.***

Name: ______________________ Date: ______________________

List the major health concerns in your order of importance. Describe each one in detail, as to its location, nature and occurrence.

Describe the most significant measures taken-to-date to improve your health concerns including physician(s) seen, diagnostic tests performed, recommendations made and treatments rendered.

List any signs and/or symptoms you may be experiencing or have experienced in each of the body systems.

Constitutional Symptoms (i.e. fever, weight loss)
Eyes
Ears, Nose, Mouth & Throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Integumentary (skin and/or breast)
Neurological
Psychiatric
Endocrine (i.e. thyroid, adrenals)
Blood/Lymphatic
Allergic/Immunologic

Concerning your past history, list, briefly describe, and give the dates of **any** past illness, sickness, accident, injury, surgery and dental work.

List and give the dosage of all prescription and non-prescription medications you are **currently taking**, when you started them, the reason for them and the results**.**

List and give the dosage of all prescription and non-prescription medications you **have taken in the past**, when you started and stopped taking them, the reason for them and the results**.**

Dr. Nate Greenstein
Patient Health History (2 of 2)

List the nutritional supplements you are currently taking, including the brand name, content and potency. Indicate the frequency which they are taken. ______

Rate your **current** stress level.
(Circle one number)
1 2 3 4 5 6 7 8 9 10
Extremely Mild | Mild | Moderate | High | Severe

Rate your stress level for the **past five years**.
(Circle one number)
1 2 3 4 5 6 7 8 9 10
Extremely Mild | Mild | Moderate | High | Severe

List the amount and type consumed or used for each of the following:
Water ______ Coffee ______ Tea ______
Soda ______ Alcohol ______ Tobacco ______

Are you on a special diet or have specific eating habits? ☐ No ☐ Yes
If yes, explain: ______

Indicate your current eating habits:
How many meals per day? ______ How many snacks per day? ______
What are your snacks? ______
Describe your average breakfast: ______
Describe your average lunch: ______
Describe your average dinner: ______

List the three **healthiest** foods you eat during the average week. ______

List the three **worst** foods you eat during the average week. ______

Do you experience any food cravings, sensitivities or allergies? ☐ No ☐ Yes
If yes, explain: ______
How many times a week do you eat fish? ______
How many times a week do you eat raw nuts or seeds? ______
How many times a week do you eat out? ______

Are you on an exercise program? ☐ No ☐ Yes
If yes, explain: ______

Do you wear: Orthotics ☐ No ☐ Yes Heel Lift ☐ No ☐ Yes Special Shoes ☐ No ☐ Yes

List and explain your family health history for all current and past significant health problems.(ex. heart disease, cancer)

How motivated are you in improving or overcoming your problems? Circle one number
1 2 3 4 5 6 7 8 9 10
Not very motivated | Somewhat motivated | Fairly motivated | Very motivated | Extremely motivated

What **expectations** do you have concerning treatment? ______

What **reservations** do you have concerning treatment? ______

What would you consider a positive outcome from treatment? ______

Please read, sign and date the following:

I completed this health history to the best of my knowledge. It is considered up-to-date, factual and an accurate representation of my health. I will notify you of any future changes with my health history.

Patient/Legal Guardian: ______ Date: ______