ABOUNDING HOPE
HEALTH OPTIONS

3050 W 151St Ct.
Suite 100
Broomfield, CO 80023
www.aboundinghope.life

(303) 494-3116 Office

History Intake

Name: _____ **Date:** _____

Age:_____ **DOB:**_____ **Sex:** **M**___ **F**___ **Weight:**_____ **Height:**_____

Allergies: Environnemental Allergy: _____

Drug Allergy: _____

Food Allergy: _____

Allergy to Alcohol? ____YES ____NO

CURRENT HEALTH PROBLEMS (List in order of importance, most important first)	Month & Year started
1.	
2.	
3.	
4.	
5.	
6.	

MAIN COMPLAINT (please describe in some details)

Are you taking immunosuppressant drugs (steroids, many arthritis drugs, etc.)?

____YES ____NO If so, what one(s)? _____

Are you on blood thinners or have bleeding tendencies?

____YES ____NO If so, explain. _____

Have you ever had a blood transfusion or organ transplant?

____YES ____NO If so, explain. _____

Do you have a pacemaker or hearing aids?

____YES ____NO If so, which one? _____

Are you on birth control (pill, IUD – copper or plastic, implant, patch, ring, shot, etc.)?

____YES ____NO If so, what type? _____

Have you ever had a hysterectomy (full or partial)?

____YES ____NO If so, which type? _____

Do you have any fillings in your teeth (amalgam, gold, porcelain, composite, resin or glass ionomer)?

____YES ____NO If so, what type? _____

Do you have any artificial body parts/reparative devices (stents, screws, wire, knees, hips, breast augmentation, teeth implants, mesh, metal plates, etc.)?

____YES ____NO If so, what type? _____

Have you ever had a Barium enema or a Barium drink for medical testing purposes?

____YES ____NO If so, explain. _____

Have you ever been diagnosed with diabetes (pre, type 1 or 2, GDM, or diabetes insipidus)?

____YES ____NO If so, what type? _____

Have you had any concussions?

____YES ____NO If so, how many and approximate dates? _____

Do you suffer with any addictions?

____YES ____NO

Do you currently or have you ever used any of the following: Tobacco (chew/cigarette), cigar, marijuana, etc.?

____YES ____NO If so, what type? _____

Did you have typical childhood vaccines?

____YES ____NO

How often do you get/have you had flu vaccines?

____NEVER ____RARELY ____EVERY FEW YEARS ____YEARLY

Have you had any other vaccine boosters in the last 10-15 years (pneumococcal, Tdap, chicken pox, shingles, Hepatitis, others)?

____YES ____NO If so, which one(s)? _____

Symptoms	Frequency					Severity				
Highlight or Star (*) the five symptoms that bother you most. **Severity:** 1 = mild / 5 = severe & intolerable Please note: SOME LINES HAVE MULTIPLE SYMPTOMS. PLEASE MAKE CLEAR WHICH ONE(S) APPLY TO YOU ON THAT LINE by underlining, **Bolding**, or circling.	DAILY	FEW DAYS/WEEK	OCCASIONALLY	RARELY	PAST SYMPTOM	1	2	3	4	5
Head, Face, Neck										
• Unexplained hair loss										
• Headache, mild or severe, seizures										
• Migraine, migraine with aura										
• Pressure in head, white matter lesions in brain (MRI)										
• Twitching of facial or other muscles										
• Facial paralysis (Bell's Palsy, Horner's syndrome)										
• Tingling of nose, (tip of) tongue, cheek or facial flushing										
• Stiff or painful neck										
• Jaw pain or stiffness										
• Dental problems										
• Sore throat, clearing throat, phlegm, or hoarseness										
• Runny nose or Sinus issues										
• Dry eyes, dry mouth										
Eyes/Vision										
• Double or blurry vision										
• Increased floating spots										
• Pain in eyes, or swelling around eyes										
• Oversensitivity to light										
• Flashing lights, peripheral waves, phantom images in corner of eyes										
Ears/Hearing										
• Decreased hearing in one or both ears, plugged ears										
• Buzzing in ears or Ringing in one or both ears										
• Pain in ears, oversensitivity to sounds										
Musculoskeletal System										
• Bone or back pain, joint pain or swelling, carpal tunnel										
• Stiffness of joints, back, neck, tennis elbow										
• Muscle pain or cramps, (Fibromyalgia)										
• Gout										

Symptoms	Frequency					Severity				
1 = mild / 5 = severe & intolerable	DAILY	FEW DAYS/WEEK	OCCASIONALLY	RARELY	PAST SYMPTOM	1	2	3	4	5
Integument (Skin) System										
• Rash, bullseye or other										
• Unexplained Hives										
Digestive and Excretory Systems										
• Diarrhea										
• Constipation										
• Hemorrhoids										
• Irritable bladder (trouble starting, stopping), interstitial cystitis, or UTI-like symptoms										
• Irritable bowel (IBS), intestinal cramping, bloating										
• Upset stomach (nausea or pain) or GERD/acid reflux										
Respiratory and Circulatory Systems										
• Shortness of breath, can't get full/satisfying breath										
• Asthma										
• Cough										
• Chest pain or rib soreness										
• Night sweats or unexplained chills										
• Heart palpitations or extra beats										
• High Blood Pressure or Low Blood Pressure										
• Endocarditis, heart blockage										
Neurologic System										
• Tremors or unexplained shaking										
• Burning or stabbing sensations in the body										
• Fatigue, Chronic Fatigue Syndrome										
• Peripheral neuropathy or partial paralysis										
• Weakness or loss of strength in hands or legs										
• Pressure in the head										
• Numbness in body, tingling, pinpricks										
• Restless legs										
• Poor balance, dizziness, difficulty walking										
• Increased motion sickness										
• Light-headedness, wooziness										

Symptoms	Frequency					Severity				
1 = mild / 5 = severe & intolerable	DAILY	FEW DAYS/WEEK	OCCASIONALLY	RARELY	PAST SYMPTOM	1	2	3	4	5
Psychological Well-being										
• Mood swings, irritability, bi-polar disorder										
• Unusual depression										
• Disorientation (getting or feeling lost)										
• Feeling as if you are losing your mind										
• Over-emotional reactions, crying easily										
• Too much sleep, or insomnia										
• Difficulty falling or staying asleep										
• Narcolepsy, sleep apnea										
• Panic attacks, anxiety, PTSD										
• OCD, ADD, ADHD										
Mental Capability										
• Memory loss (short or long term)										
• Confusion, difficulty thinking										
• Difficulty with concentration										
• Difficulty with reading										
• Going to the wrong place										
• Speech difficulty (slurred or slow)										
• Difficulty finding commonly used words										
• Stammering speech										
• Forgetting how to perform simple tasks										
Reproduction and Sexuality										
• Loss of sex drive										
• Sexual dysfunction										
• Unexplained menstrual pain, irregularity										
• Unexplained breast pain, discharge										
• Yeast Infections										
• Testicular or pelvic pain										

Symptoms	Frequency					Severity				
1 = mild / 5 = severe & intolerable	DAILY	FEW DAYS/WEEK	OCCASIONALLY	RARELY	PAST SYMPTOM	1	2	3	4	5
General Well-being										
• Phantom smells										
• Unexplained weight gain or loss										
• Extreme fatigue										
• Swollen glands or lymph nodes										
• Unexplained fevers (high or low grade)										
• Continual infections (sinus, kidney, eye, etc.)										
• Symptoms seem to change, come and go										
• Pain migrates (moves) to different body parts										
• Low body temperature										
• Allergies or chemical sensitivities										
• Increased effect from alcohol and possible worse hangover										
• Early on, experienced a "flu-like" illness, after which you have not felt well. If yes, mark "past symptom" and severity)										
Additional Symptoms										
• Psoriasis										
• Vitiligo										
• Warts										
• Dry skin, dandruff										
• Dark circles under eyes										
• Negative reactions to vaccines										
• Flatulence										
• Poor skin integrity										
• Excessive snoring										
• Brittle nails										
Other										
•										
•										
•										

If complaining of pain, how do you describe your pain?

Does the pain refer or radiate to other places? Does it change or come and go? Please explain

What factors worsen your pain?

What factors decrease your pain?

Is your pain resulting from an accident?

____YES ____NO If so, explain. _____

Diagnoses received to date:

List investigations done so far and their results:

- ☐ MRI
- ☐ CT Scan
- ☐ X-Ray
- ☐ Endoscopy
- ☐ Other: _____

Treatment received up-to-date for your current problem(s):

List all *CURRENT* medications and supplements:

List all *PAST* medications and supplements:

Check or highlight all treatment received in the past or being currently received:

- ☐ Bed rest
- ☐ Traction
- ☐ Nerve blocks
- ☐ Exercise
- ☐ Hypnosis
- ☐ Chiropractor
- ☐ Pharmaceuticals
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Electrical stimulation
- ☐ Surgery
- ☐ Acupuncture
- ☐ Epidural blocks
- ☐ Heat treatment
- ☐ Physical Therapy
- ☐ Supplements
- ☐ Other

List of all Surgical Operations	**Year Performed**
1.	
2.	
3.	
4.	
5.	

List of Cancer Diagnoses and Treatments	**Year Diagnosed**

Other States and Countries *Traveled To* (Important)	**Approximate Dates of Travel (year)**

Other State and Countries *Lived In* (Important)	**Years**

<u>Daily Habits</u> (E.g. walking/exercising; smoking; daily alcoholic drink, coffee, soda; computer; TV, etc.)

<u>Past & Present Hobbies</u> Please list all you can think of. This information is used to determine exposure. (E.g. fishing, hunting, stained glass, painting, reading, gardening, welding, building things, auto repair, etc.)

<u>Family History of Illnesses</u> (Please *also* indicate where family member lived just before/during illness)

Are you (or have you ever been) on well water? ____YES ____NO

Do you live under or very close to high voltage power lines? ____YES ____NO

Do you or have you ever lived near a nuclear power plant/radiation zone? ____YES ____NO

Do you have or have you ever had pets?

____YES ____NO **If so, what type?** _____

_____

Have you ever been bitten by a tick that you are aware of?

____YES ____NO **If so, where were you (State/Country) when this occurred and what was the approximate year? _____**

Employment - *Where you worked and what you did*. (Important) This helps determine potential exposure to toxins, pathogens, etc.	**Approximate Dates by Year**

Thank you! I know this is long, but it will save time on exam day and will assist in a more thorough exam.