

# HEALTH INVENTORY FORM



NYC | WORLD

Name (First Name and Last Initial ONLY) \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Gender  M  F  Non-conforming Preferred pronouns \_\_\_\_\_

Occupation \_\_\_\_\_

How did you hear about AHE NYC | World Student Clinic? \_\_\_\_\_

## Primary Health Concerns

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Please check all that apply to you and list approximate dates.

<input type="checkbox"/> Acne	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Nightmares
<input type="checkbox"/> AIDS	<input type="checkbox"/> Fibroids (uterine)	<input type="checkbox"/> Overweight
<input type="checkbox"/> Alcohol/drug problem	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Panic Attack
<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pelvic Infection
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gout	<input type="checkbox"/> Periodontal Disease
<input type="checkbox"/> Antibiotics (1x a year)	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pneumonia

# HEALTH INVENTORY FORM



NYC | WORLD

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Premenstrual Tension
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Psychotherapy
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Binge Eating	<input type="checkbox"/> Hernia	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Bladder infections	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures/epilepsy
<input type="checkbox"/> Blood clots	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> STI's
<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Hives	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Infection/stones	<input type="checkbox"/> Steroid Use
<input type="checkbox"/> Cataract (s)	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chemical Sensitivity	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Colitis	<input type="checkbox"/> Migraine	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mumps	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Neurological Problem	<input type="checkbox"/> Vaccine Reaction
<input type="checkbox"/> Eczema		<input type="checkbox"/> Warts

# HEALTH INVENTORY FORM



NYC | WORLD

## Personal Medical History

Current Prescription Medications (List prescribing doctor)	Date Started

### Vitamin/Mineral Supplements

**Surgery:** List all procedures and approximate dates

**Hospitalizations:** Reasons/Dates

**Accidents, Traumatic Injuries, Broken Bones:**

**Allergies**

**Food Allergies**

# HEALTH INVENTORY FORM



NYC | WORLD

Have you used Homeopathy before?

Yes  No

Have you worked with a Homeopath before?

Yes  No

If yes, when last seen: \_\_\_\_\_

List any homeopathic remedy or remedies you have taken within the past 2 months:

List other therapies or healing modalities (conventional or alternative) you have used to address your health concerns:

## Diet & Lifestyle

**Food Cravings**

**Alcohol/Recreational Drug Use**

Do you drink alcohol or use drugs?

How much/often?

**Caffeine**

Do you drink coffee or tea?

How much/often?

**Cigarettes**

Do you smoke now or did you in the past?

How much/often?

# HEALTH INVENTORY FORM



NYC | WORLD

<b>Diet Soda/Artificial Sweeteners</b> Describe your use:	<b>Refined Sugars/Processed Foods:</b> Describe your use:
<b>Hobbies</b>  How often do you do them?	<b>Living Situation</b>
<b>Exercise:</b> Describe the ways you get your body moving. Do you feel you get enough physical activity?	<b>Food:</b> Do you feel you eat a healthy and well-balanced diet? Do you need guidance/support?
<b>Worry/Anxiety:</b> Do you have particular issues that worry you? How does this impact your life?	<b>Healthy Relationships:</b> Do you have a supportive family/community?

# HEALTH INVENTORY FORM



NYC | WORLD

<p><b>Unhealthy Relationships:</b> Have you been a victim of domestic abuse or troubling relationships?</p>	<p><b>Spiritual Life:</b> Do you have a spiritual practice? Is your spiritual life fulfilling and satisfactory?</p>
<p><b>Intimacy:</b> Are you satisfied with your sexual/intimate life?</p>	<p><b>Anything else?</b> Please indicate any topics you want to address in your consultation.</p>

**Hormonal Health (Check all that apply or answer as applicable)**

Male	Female	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Enlarged prostate</li> <li><input type="checkbox"/> Decreased urine stream</li> <li><input type="checkbox"/> Unable to interrupt stream</li> <li><input type="checkbox"/> Dribbling after urination</li> <li><input type="checkbox"/> Pus or drainage from penis</li> <li><input type="checkbox"/> Genital swelling</li> <li><input type="checkbox"/> Rash/eruptions</li> <li><input type="checkbox"/> Problems with sexual function</li> </ul> <p>Comments:</p>	<p>Date of last menstrual period _____</p> <p>Length of cycle _____</p> <p>Length of period _____</p> <p>Age menstruation began _____</p> <p>Menopause (list date) _____</p> <p>Number of pregnancies _____</p> <p>Number of live births _____</p> <p>Number of abortions/miscarriages _____</p> <p>Comments:</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Spotting between periods</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Issues with fertility</li> <li><input type="checkbox"/> Problems with sexual function</li> </ul>



## Life Changes

In the past year, what changes have occurred in your:

**Personal Life:**

**Family Life:**

**Social Life:**

**Work Life:**

**Sex Life:**

# HEALTH INVENTORY FORM



NYC | WORLD

## Family History

Age

If passed, cause of death

Father \_\_\_\_\_

Mother \_\_\_\_\_

Siblings \_\_\_\_\_

Children \_\_\_\_\_

**Check all that apply to blood relatives, and list relationship.**

<input type="checkbox"/> Alcohol/drug problem	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Allergy	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Obesity
<input type="checkbox"/> Autoimmune disorder	<input type="checkbox"/> Skin Disease
<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Suicide
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Epilepsy/seizure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Heart Disease	