GONSTEAD SPINE INSTITUTE

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PATIENT HEALTH ASSESSMENT FORM

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Sex: M F Date of Birth: _____

Please read each description and (circle) any applicable symptoms that relate to you

Cardiovascular
- Atrial Fibrilillation
- Congestive Heart Failure
- High Blood Pressure
- Stroke
- High Cholesterol
- Other? _____

Diabetes
- Type 1 (Juvenile Onset)
- Type 2 (Adult Onset)

Digestive Tract
- Gastric Esophageal Reflux
- Hemorrhoids
- Irritable Bowel Syndrome (IBS)
- Ulcer
- Hiatal Hernia
- Constipation / Diarrhea
- Other? _____

Female – Reproductive/Urinary
- Menopausal Symptoms
- Painful Menstruation (Dysmenorrhea)
- Urinary Tract Infections
- Other? _____

Male – Reproductive/Urinary
- Benign Prostatic Hypertrophy (BPH)
- Erectile Dysfunction
- Urinary Tract Infections
- Other? _____

Musculoskeletal
- Fibromyalgia
- Muscle Wasting Syndrome
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Soft Tissue Trauma
- Scoliosis
- Other? _____

Nervous System
- Clinical Depression
- Epilepsy
- Migraine Headache
- Parkinson's Disease
- Schizophrenia
- Sleep Apnea or other Sleep Disorders
- Other? _____

Respiratory
- Asthma
- Emphysema
- COPD
- Other? _____

Skin
- Eczema
- Psoriasis
- Other? _____

Other
- Cancer (specify) _____
- HIV

Allergy

Food (I.e. shellfish) please specify _____

Medications (I.e. penicillin) please specify _____

Seasonal (I.e. hay fever) please specify _____

I'm currently taking: Please list below.

A. Vitamins, Herbs Supplements, or Over the Counter Medications?

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

B. Prescription Medications?

1. _____ 2. _____ 3. _____ 4. _____ 5. _____