Health Journal of _____

Date of Birth: _____

Smoking Status: _____ **Alcohol Consumption:** _____
Pharmacy: _____ **Phone:** _____

Birth Name: _____ **Preferred Name:** _____
Gender: _____ **Pronouns:** _____
Phone: _____ **E-mail:** _____
Address: _____

Primary Insurance: _____
ID #: _____ Group #: _____

Secondary Insurance: _____
ID #: _____ Group #: _____

Allergies

1. _____ Causes: _____
2. _____ Causes: _____
3. _____ Causes: _____
4. _____ Causes: _____
5. _____ Causes: _____
6. _____ Causes: _____
7. _____ Causes: _____
8. _____ Causes: _____
9. _____ Causes: _____
10. _____ Causes: _____
11. _____ Causes: _____
12. _____ Causes: _____
13. _____ Causes: _____

Medications Taking

1. _____ Dosage:_____
2. _____ Dosage:_____
3. _____ Dosage:_____
4. _____ Dosage:_____
5. _____ Dosage:_____
6. _____ Dosage:_____
7. _____ Dosage:_____
8. _____ Dosage:_____
9. _____ Dosage:_____
10. _____ Dosage:_____
11. _____ Dosage:_____

12. _____ Dosage:_____
13. _____ Dosage:_____
14. _____ Dosage:_____
15. _____ Dosage:_____
16. _____ Dosage:_____
17. _____ Dosage:_____
18. _____ Dosage:_____
19. _____ Dosage:_____
20. _____ Dosage:_____
21. _____ Dosage:_____
22. _____ Dosage:_____
23. _____ Dosage:_____
24. _____ Dosage:_____
25. _____ Dosage:_____
26. _____ Dosage:_____
27. _____ Dosage:_____
28. _____ Dosage:_____
29. _____ Dosage:_____
30. _____ Dosage:_____

Known Health Issues

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____

24. _____
25. _____

Primary Care Physician: _____
Address: _____
Phone Number: _____

Specialist: _____
Address: _____
Phone Number: _____

Therapist: _____
Address: _____
Phone Number: _____

Emergency Contact: _____ Phone: _____
Relationship: _____ Alternate Phone: _____

Emergency Contact: _____ Phone: _____
Relationship: _____ Alternate Phone: _____

Previous Surgeries

1._____ Year: _____
2._____ Year: _____
3. _____ Year: _____
4. _____ Year: _____
5. _____ Year: _____
6. _____ Year: _____
7. _____ Year: _____
8. _____ Year: _____
9. _____ Year: _____
10. _____ Year: _____
11. _____ Year: _____
12. _____ Year: _____
13. _____ Year: _____
14. _____ Year: _____
15. _____ Year: _____
16. _____ Year: _____
17. _____ Year: _____
18. _____ Year: _____
19. _____ Year: _____
20. _____ Year: _____
21. _____ Year: _____
22. _____ Year: _____

Family History

Mother ◯ Alive ◯ Deceased

Father ◯ Alive ◯ Deceased

Sibling ◯ Alive ◯ Deceased

Sibling ◯ Alive ◯ Deceased

Maternal Grandmother ◯ Alive ◯ Deceased

Maternal Grandfather ◯ Alive ◯ Deceased

Paternal Grandmother ◯ Alive ◯ Deceased

Paternal Grandfather ◯ Alive ◯ Deceased

Daily Health Journal

Pain Scale: 1 mild, 5 moderate, 10 unbearable pain

Date _____

Temperature: _____ **Weight:** _____ **Blood Pressure:** _____/_____ **Heart Rate:** _____beats/minute

Weather

Temperature: _____F/_____C UV Index: ___/10 Pollen Count: ____

◯ Hot ◯ Warm ◯ Cold ◯ Cool ◯ Sunny ◯ Cloudy ◯ Overcast ◯ Foggy

◯ Rain ◯ Drizzle ◯ Snow ◯ Windy ◯ Damp ◯ Humid ◯ Dry ◯ Stormy ◯ Icy

Medications

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

◯ _____ Dosage: _____ Purpose: _____

Non-Medication Treatments

◯ _____ Purpose: _____

◯ _____ Purpose: _____

◯ _____ Purpose: _____

◯ _____ Purpose: _____

◯ _____ Purpose: _____

Sleep the Night Before

Total Estimated Hours Slept: _____ ◯ Restless ◯ Sound Time to Bed: _____ Time Out of Bed: ___

Any Naps? ◯ Yes ◯ No How Many? _____ How Long? _____

Overall

Mood: ◯ Excellent ◯ Great ◯ Good ◯ Fair ◯ Poor ◯ Very Poor

Health: ◯ Excellent ◯ Great ◯ Good ◯ Fair ◯ Poor ◯ Very Poor

Pain: ◯ Excellent ◯ Great ◯ Good ◯ Fair ◯ Poor ◯ Very Poor

Stress: ◯ Excellent ◯ Great ◯ Good ◯ Fair ◯ Poor ◯ Very Poor

Mobility: ◯ Excellent ◯ Great ◯ Good ◯ Fair ◯ Poor ◯ Very Poor

Period and Cramping

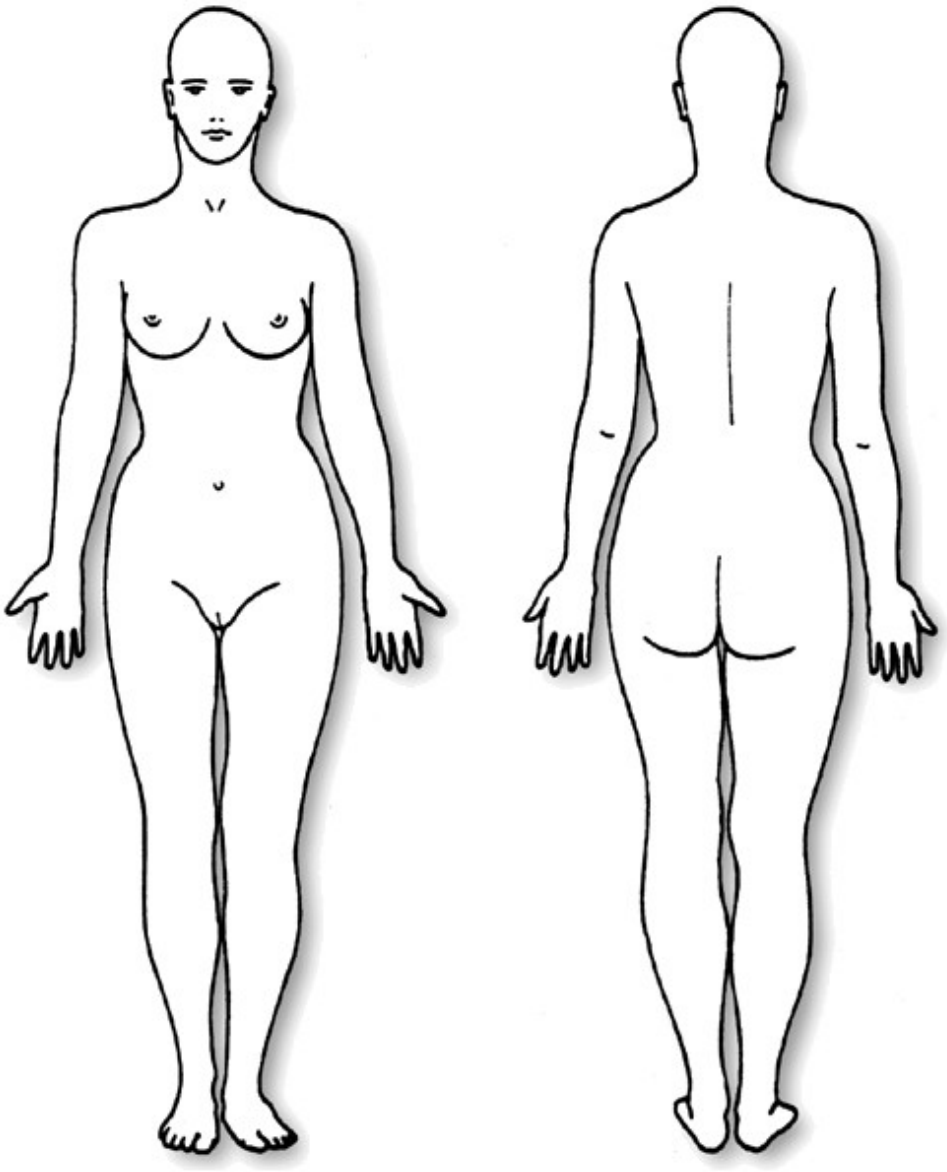
Period Today? ◯ Yes ◯ No If No, Any Bleeding or Spotting? ◯ Yes ◯ No How Much? _____

If Yes, How Heavy Is the Flow? ◯ Heavy ◯ Moderate ◯ Light ◯ Almost Non-Existent

Cramping? ◯ Yes ◯ No Level of Pain: ____/10
Back Pain? ◯ Yes ◯ No Level of Pain: ____/10
Headache? ◯ Yes ◯ No Level of Pain: ____/10
Mood Swings? ◯ Yes ◯ No Fatigue? ◯ Yes ◯ No Painful Bowel Movement? ◯ Yes ◯ No
Depression? ◯ Yes ◯ No How Disruptive? ◯ Extremely ◯ Very Much ◯ Not Much
Breast Tenderness? ◯ Yes ◯ No Nipple Pain and Sensitivity? ◯ Yes ◯ No Acne? ◯ Yes ◯ No
Appetite Changes? ◯ Yes ◯ No If Yes, ◯ Decrease ◯ Increase
Food Cravings? ◯ Yes ◯ No If Yes, What? _____

Pain

Mark any pain you've had today with a number. Then, in the section below the figure, make note next to the corresponding number of the level of pain and its duration and make note of any treatments, medications, or exercises you used to try to help.



Notes on Pain

❶ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

❷ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

❸ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

❹ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

❺ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

❻ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

❼ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

❽ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

❾ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____

Notes on Pain

❿ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

⓫ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

⓬ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

⓭ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

⓮ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

⓯ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

⓰ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

⓱ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____
_____

⓲ Type of Pain: _____
Duration and Frequency: _____ Level of Pain: ___/10
Treatments, Exercises, or Medications Tried: _____

Food and Drink

Cups of Water: ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

Breakfast Time: _____ AM/PM

_____

_____

_____

Lunch Time: _____ AM/PM

_____

_____

_____

Dinner Time: _____ AM/PM

_____

_____

_____

Snacks Time: _____ AM/PM Time: _____ AM/PM Time: _____ AM/PM

_____

_____

_____

Beverages Time: _____ AM/PM Time: _____ AM/PM Time: _____ AM/PM

_____

_____

_____

Physical Activity

Activity: _____

Time: _____ AM/PM Duration: _____ Weight Used: _____ Sets: _____ Reps: _____

Activity: _____

Time: _____ AM/PM Duration: _____ Weight Used: _____ Sets: _____ Reps: _____

Activity: _____

Time: _____ AM/PM Duration: _____ Weight Used: _____ Sets: _____ Reps: _____

Activity: _____

Time: _____ AM/PM Duration: _____ Weight Used: _____ Sets: _____ Reps: _____

Activity: _____

Time: _____ AM/PM Duration: _____ Weight Used: _____ Sets: _____ Reps: _____

Activity: _____

Time: _____ AM/PM Duration: _____ Weight Used: _____ Sets: _____ Reps: _____

General

Hearing and Vision

Numbness? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Hearing Loss? ◯ Yes ◯ No Which Ear? ◯ Right ◯ Left How Long? _____
Notes: _____
Ringing in Ears? ◯ Yes ◯ No Which Ear? ◯ Right ◯ Left How Long? _____
Notes: _____
Static Sounds? ◯ Yes ◯ No Which Ear? ◯ Right ◯ Left How Long? _____
Notes: _____
Vision Loss? ◯ Yes ◯ No Which Eye? ◯ Right ◯ Left How Long? _____
Notes: _____
Vision Blurriness? ◯ Yes ◯ No Which Eye? ◯ Right ◯ Left How Long? _____
Notes: _____

Head, Brain, and Face

Balance and Coordination: ◯ Excellent ◯ Great ◯ Good ◯ Fair ◯ Poor ◯ Extremely Poor
Notes: _____
Nasal/Sinus Issues? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Dental Issues? ◯ Yes ◯ No Describe: _____
_____
_____ How Long? _____
Headache? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Migraine? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Speech Issues? ◯ Yes ◯ No Describe: _____
_____
_____ How Long? _____
Brain Fog? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _____
Notes: _____
Confusion? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _____
Notes: _____
Memory Issues? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _____
Notes: _____
Concentration Issues? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _____
Notes: _____
Nightmares? ◯ Yes ◯ No Notes: _____
Notes: _____
Dizziness? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _____
Notes: _____
Room Spinning? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _____
Notes: _____

Numbness? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Stiffness? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Muscle Spasms? ◯ Yes ◯ No Where? _____ How Long? _____
How Frequently? _____

Upper Extremities, Neck, and Back

Tremors? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Numbness? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Stiffness? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Muscle Spasms? ◯ Yes ◯ No Where? _____ How Long? _____
How Frequently? _____

Chest, Torso, and Internal Organs

Heart Palpitations? ◯ Yes ◯ No How Long? _____ Trigger? _____
Notes: _____
Chest Pain? ◯ Yes ◯ No How Long? _____ Trigger? _____
Notes: _____
Respiratory Issues? ◯ Yes ◯ No How Long? _____ Trigger? _____
Notes: _____
Wheezing? ◯ Yes ◯ No How Long? _____ Trigger? _____
Notes: _____
Phlegm? ◯ Yes ◯ No How Long? _____ Cause? _____
Notes: _____
Bowel Movement? ◯ Yes ◯ No Notes: _____
Indigestion? ◯ Yes ◯ No How Long? _____ Trigger? _____
Notes: _____
Appetite Change? ◯ Yes ◯ No How Did It Change? ◯ Increase ◯ Decrease
Notes: _____
Unexplained Pain? ◯ Yes ◯ No Notes: _____
Nausea? ◯ Yes ◯ No Notes: _____
Numbness? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Stiffness? ◯ Yes ◯ No Where? _____ How Long? _____
Notes: _____
Muscle Spasms? ◯ Yes ◯ No Where? _____ How Long? _____
How Frequently? _____

Lower Extremities

Restless Legs? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _____

Numbness? ◯ Yes ◯ No Where? ________________ How Long? __________________
Notes: ____
Stiffness? ◯ Yes ◯ No Where? ________________ How Long? __________________
Notes:____
Muscle Spasms? ◯ Yes ◯ No Where? _________________ How Long? ____________
How Frequently? ___________________

Overall

Eczema Flare? ◯ Yes ◯ No Where? ________________ How Long? __________________
Notes: ____
Fatigue? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _________________
Notes: ____
Weakness? ◯ Yes ◯ No All Day? ◯ Yes ◯ No If No, How Long? _________________
Notes: ____
Numbness? ◯ Yes ◯ No Where? ________________ How Long? __________________
Notes: ____
Stiffness? ◯ Yes ◯ No Where? ________________ How Long? __________________
Notes:____
Infection? Where? ____________________________________ Since When? __________
Pain? ◯ Yes ◯ No Redness? ◯ Yes ◯ No Cause: __________________
____
Infection? Where? ____________________________________ Since When? __________
Pain? ◯ Yes ◯ No Redness? ◯ Yes ◯ No Cause: __________________
____
Infection? Where? ____________________________________ Since When? __________
Pain? ◯ Yes ◯ No Redness? ◯ Yes ◯ No Cause: __________________
____
Infection? Where? ____________________________________ Since When? __________
Pain? ◯ Yes ◯ No Redness? ◯ Yes ◯ No Cause: __________________
____
Infection? Where? ____________________________________ Since When? __________
Pain? ◯ Yes ◯ No Redness? ◯ Yes ◯ No Cause: __________________
____
Infection? Where? ____________________________________ Since When? __________
Pain? ◯ Yes ◯ No Redness? ◯ Yes ◯ No Cause: __________________
____
Infection? Where? ____________________________________ Since When? __________
Pain? ◯ Yes ◯ No Redness? ◯ Yes ◯ No Cause: __________________
____
Infection? Where? ____________________________________ Since When? __________
Pain? ◯ Yes ◯ No Redness? ◯ Yes ◯ No Cause: __________________
____

Notes

____
____

Mental Health

Suicidal Ideations?

◯ Yes ◯ No All Day? ◯ Yes ◯ No If Yes, How Long? _____

Notes:_____

Suicide Plan Making or Research?

◯ Yes ◯ No All Day? ◯ Yes ◯ No If Yes, How Long? _____

Notes:_____

Steps Taken to Carry Out Plan?

_____

_____

Steps Taken to Prevent Suicide?

_____

_____

_____

☆☆☆☆☆☆☆☆

Rate the disruptiveness of the disorder on a scale of 1 to 10, with 1 being barely a problem and 10 being extremely disruptive to your day.

_____/10: Disorder: _____

Notes: _____

_____

_____

Triggers? _____

Coping Method: _____

_____

_____

_____/10: Disorder: _____

Notes: _____

_____

_____

Triggers? _____

Coping Method: _____

_____

_____

_____/10: Disorder: _____

Notes: _____

_____

_____

Triggers? _____

Coping Method: _____

_____/10: Disorder: _____

Notes: _____

_____

_____

Triggers? _____

Coping Method: _____

_____

_____

_____/10: Disorder: _____

Notes: _____

_____

_____

Triggers? _____

Coping Method: _____

_____

_____

_____/10: Disorder: _____

Notes: _____

_____

_____

Triggers? _____

Coping Method: _____

_____

_____

_____/10: Disorder: _____

Notes: _____

_____

_____

Triggers? _____

Coping Method: _____

_____

_____

Notes

_____

_____

_____

_____

_____

Doctors Visits Today

Doctor: _____ Appt Time: _____ Time Seen: _____
Purpose: _____
_____
_____
Notes: _____
_____
_____
_____
_____
Blood Pressure: _____/_____ Heart Rate: _____/minute Temperature: _____ Weight: _____
Medications/Treatments Prescribed _____
_____
_____
_____
Blood Work? ◯ Yes ◯ No Results: _____
_____
Follow Up with Dr. _____ on _____at _____ AM/PM
Referral Needed? ◯ Yes ◯ No
Follow Up with Dr. _____ on _____at _____ AM/PM
Referral Needed? ◯ Yes ◯ No

☆☆☆☆☆☆☆☆

Doctor: _____ Appt Time: _____ Time Seen: _____
Purpose: _____
_____
_____
Notes: _____
_____
_____
_____
_____
Blood Pressure: _____/_____ Heart Rate: _____/minute Temperature: _____ Weight: _____
Medications/Treatments Prescribed _____
_____
_____
_____
Blood Work? ◯ Yes ◯ No Results: _____
_____
Follow Up with Dr. _____ on _____at _____ AM/PM
Referral Needed? ◯ Yes ◯ No
Follow Up with Dr. _____ on _____at _____ AM/PM
Referral Needed? ◯ Yes ◯ No

Doctors Visits Today

Doctor: _____ Appt Time: _____ Time Seen: _____
Purpose: _____
_____
_____
Notes: _____
_____
_____
_____
_____
Blood Pressure: _____/_____ Heart Rate: _____/minute Temperature: _____ Weight: _____
Medications/Treatments Prescribed _____
_____
_____
_____
Blood Work? ◯ Yes ◯ No Results: _____
_____
Follow Up with Dr. _____ on _____at _____ AM/PM
Referral Needed? ◯ Yes ◯ No
Follow Up with Dr. _____ on _____at _____ AM/PM
Referral Needed? ◯ Yes ◯ No

☆☆☆☆☆☆☆☆

Doctor: _____ Appt Time: _____ Time Seen: _____
Purpose: _____
_____
_____
Notes: _____
_____
_____
_____
_____
Blood Pressure: _____/_____ Heart Rate: _____/minute Temperature: _____ Weight: _____
Medications/Treatments Prescribed _____
_____
_____
_____
Blood Work? ◯ Yes ◯ No Results: _____
_____
Follow Up with Dr. _____ on _____at _____ AM/PM
Referral Needed? ◯ Yes ◯ No
Follow Up with Dr. _____ on _____at _____ AM/PM
Referral Needed? ◯ Yes ◯ No

Past and Current Medications

Make note of any allergic reactions to these medications by highlighting with a bright color.

Medication: ____ Dose: ___________
Reason: ___________________________ Prescribing Doctor: _________________________
Date Started: ______________ Date Stopped: ________________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: ___________
Reason: ___________________________ Prescribing Doctor: _________________________
Date Started: ______________ Date Stopped: ________________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: ___________
Reason: ___________________________ Prescribing Doctor: _________________________
Date Started: ______________ Date Stopped: ________________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: ___________
Reason: ___________________________ Prescribing Doctor: _________________________
Date Started: ______________ Date Stopped: ________________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: ___________
Reason: ___________________________ Prescribing Doctor: _________________________
Date Started: ______________ Date Stopped: ________________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: ___________
Reason: ___________________________ Prescribing Doctor: _________________________
Date Started: ______________ Date Stopped: ________________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: __________
Reason: __________________________ Prescribing Doctor: ________________________
Date Started: _____________ Date Stopped: _______________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: __________
Reason: __________________________ Prescribing Doctor: ________________________
Date Started: _____________ Date Stopped: _______________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: __________
Reason: __________________________ Prescribing Doctor: ________________________
Date Started: _____________ Date Stopped: _______________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: __________
Reason: __________________________ Prescribing Doctor: ________________________
Date Started: _____________ Date Stopped: _______________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: __________
Reason: __________________________ Prescribing Doctor: ________________________
Date Started: _____________ Date Stopped: _______________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆

Medication: ____ Dose: __________
Reason: __________________________ Prescribing Doctor: ________________________
Date Started: _____________ Date Stopped: _______________
Reason for Stopping: ____

☆☆☆☆☆☆☆☆