Male Health History Questionnaire
(To be completed by the patient)

Name _____Date _____
Date of Birth _____ Age _____
Weight _____ Height _____

Please describe your symptoms in detail (use other side if necessary):
_____
_____
_____
_____

Prescription Drug Usage

Please check if you use an of the following and then list exact names of any medications you are currently using:
 Antacids, Zantac, Pepcid AC, Rolaids, etc.
 Chemotherapy
 Laxatives
 Ulcer medications
 Antibiotic / Antifungal
 Anti-diabetic / Insulin
 Thyroid
0 Anti-depressants
0 Aspirin/acetaminophen
0 Heart Medications
0 Cortisone/Anti-inflammatory
0 High blood pressure medication
0 Statins/cholesterol lowering medications
0 Relaxants/Sleeping Pills
 Hormones - If so, what? _____ When? _____ Dosage?
_____

Please list names of any medications you are currently taking - list dosage and length of time.
_____
_____
_____

Please list anything that you **believe** you are allergic to or sensitive to:
_____
_____

_____

What allergies or sensitivities have been **confirmed** by any type of testing?

_____
_____
_____

How long have you had your symptoms? _____
Are your symptoms: **mild** **moderate** **severe**
Each year, are your symptoms getting : **better** **worse** **no change**

Supplement / Vitamin Usage - Please list any you are currently taking:

_____
_____
_____
_____

Surgeries, Accidents, Traumas -
Please list any surgeries, accidents or traumas you have had along with the dates.

_____
_____
_____

Lifestyle

Dietary Habits -
Describe the foods you normally eat:
Breakfast

_____
_____

Lunch

_____
_____

Dinner

_____
_____

Snacks

_____

Do you consume the following? If so, **how much**?
1. Soda or carbonated beverages ____ Yes ____ No _____
2. White flour products ____ Yes ____ No _____
3. Fried foods ____ Yes ____ No _____
4. Coffee ____ Yes ____ No _____
5. Fast foods regularly ____ Yes ____ No _____
6. Sweets and / or refined carbohydrates ____ Yes ____ No

_____
7. Alcoholic beverages ____ Yes ____ No _____

8. Tobacco products ____ Yes ____ No _____
Are you a vegetarian? ____ Yes ____ No
Are you currently involved in an exercise program? ____ Yes ____ No

How would you rate your stress level? (1 = Low, 10 = Extreme) 1 2 3 4 5 6 7 8 9 1 0
How do you rate your stress handling? (1 = Poor, 10 = Excellent) 1 2 3 4 5 6 7 8 9 1 0

Male Anatomy / Reproductive Health (to be completed by all women)

Have you had a vasectomy? ____ Yes ____ No When? _____
Experienced any symptoms related to the vasectomy? ____ Yes ____ No
If so, please explain:
_____
_____
Reverse vasectomy? ____ Yes ____ No When? _____
Do you have any history of prostate problems? ____ Yes ____ No
If so, please explain:
_____
_____

When was your last prostate exam? _____
What were your most recent PSA results? _____
Does your bladder always feel full? ____ Yes ____ No
Do you experience inconsistent pressure or pain during urine? ____ Yes ____ No
Does ejaculation cause pain? ____ Yes ____ No
Do you experience low sex drive? ____ Yes ____ No
Do you have premature ejaculation? ____ Yes ____ No

Sleep

How well do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

What is the average number of hours you most often sleep each night? _____
Do you wake up with night sweats? ____ Yes ____ No
When you wake in the morning do you still feel tired? ____ Yes ____ No
If yes, how often?
_____
Do you keep your room completely dark at night? ____ Yes ____ No

Signs & Symptoms (Instructions: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month) 2 = Moderate (happens weekly), 3 = Severe (happens almost daily) If you do not know an answer to a question or if it does not pertain to you simply leave it blank.

Section 1:	
Do you experience bloating?	1 2 3
Fullness for extended time after meals?	1 2 3
Fatigue or low energy after eating?	1 2 3
Do you experience indigestion?	1 2 3
Uncomfortable / adverse reactions to food:	1 2 3
Weight gain?	1 2 3
Trouble losing weight?	1 2 3
Weight loss?	1 2 3
Water retention?	1 2 3
Belching / gas? (circle)	1 2 3
Stomach burning / nausea? (circle)	1 2 3
Section 2:	
Do you suffer with constipation?	1 2 3
Light colored stool?	1 2 3
Loose stools?	1 2 3
Diarrhea?	1 2 3
Persistent gas?	1 2 3
Digestive problems?	1 2 3
Section 3:	
Low blood sugar / hypoglycemia?	1 2 3
Sweet cravings?	1 2 3
Carbohydrate cravings?	1 2 3
Caffeine / stimulant cravings? (circle)	1 2 3
Constant hunger?	1 2 3
Section 4:	
Low mood / depression? (circle)	1 2 3
Mood swings?	1 2 3
Irritability?	1 2 3
Anxiety?	1 2 3
Anger / aggression? (circle)	1 2 3
Nervousness?	1 2 3
Overly reactive?	1 2 3
Short fuse?	1 2 3
Section 5:	

Discouragement / pessimism? (circle)	1	2	3
Decreased interest in activities / relationships? (circle)	1	2	3
Decreased initiative / motivation / drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue	1	2	3
Lowered self-esteem / self image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness / crying? (circle)	1	2	3

Section 7:

Decrease in strength / stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decreased lean muscle mass?	1	2	3
Muscle soreness / weakness? (circle)	1	2	3
Body / joint aches? (circle)	1	2	3
Increased fat on hips / breasts / thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches / migraines? (circle)	1	2	3
Muscle pain / joint aches / backache? (circle)	1	2	3

Section 9:

Head hair loss / body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

Section 10:

Lowered libido?	1	2	3
Erectile Dysfunction?	1	2	3
Pain with ejaculation?	1	2	3
Frequent need to urinate?	1	2	3
Urination is delayed/strained/incomplete?	1	2	3
Pain with urination?	1	2	3
Blood in the urine?	1	2	3
Bone loss / osteoporosis?	1	2	3
Celiac Disease?	1	2	3
Lyme Disease?	1	2	3
Weak Immune system?	1	2	3
Liver Dysfunction?	1	2	3

Sinusitis?	1 2 3
Itchy/Watery Eyes?	1 2 3
Asthma?	1 2 3

Informed Consent Agreement (CBT)

I understand that I should not discontinue any health care provided by other health care providers, and that I should fully inform other health care providers about any changes in my symptoms or conditions that result from the application of CBT procedures. I understand that I may discontinue my CBT treatment at any time. However, I understand that the premature termination of my care may be detrimental to any improvement I have obtained.

I understand that Dr. Hamel is a chiropractic physician, and no a medical doctor or a doctor of osteopathy, and she does not practice medicine. I understand that CBT techniques and procedures were developed by Dr. Smith DC, and that they are an experimental, alternative form of healthcare which is not yet proven by medical science, not yet subjected to chiropractic peer review nor taught in chiropractic colleges, and are not covered by any health insurance, Medicare or Medicaid.

I have read the above statements, and I have been provided the opportunity to as any questions regarding CBT procedures. I have also been informed that I am to notify Dr. Hamel if I develop any problems during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of care. By signing below, I agree to the terms set forth above.

I have executed the foregoing this ____ day of _____

_____ _____

Signature Printed Name

_____ _____

If Minor, signature of parent or guardian Guardian's printed name

_____ _____

Witness signature Witness Printed Name