Big Sky Wellness Center
265 Foys Canyon Rd.
Kalispell, MT 59901
406-755-4119 (office)
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BIG SKY WELLNESS CENTER
More Health. More Life.

UPDATED PATIENT HEALTH HISTORY

Date: _____

Name: _____

Physical Address: _____ Occupation: _____

City: _____State:_____ Zip: _____ Employer: _____

Mailing Address: _____

City: _____State:____ Zip: _____

Home Phone #: _____ E-Mail: _____

Cell Phone #: _____

Please list any <u>new</u> primary concerns since our last appointment. (Please tell me about it in <u>as much detail as possible</u>.)

1.

2.

3.

Have you seen any other healthcare providers for ANY reason since our last appointment? If so, who? For what?

Since our last appointment, have you had any <u>accidents</u> or <u>falls</u>? If so, when?

□Auto: _____

□Recreation: _____

□Sports: _____

□Work Related: _____

□Other: _____

Are you taking any NEW medications (prescription or over-the-counter) since our last appointment? If so, please list.

Are you taking any NEW supplements since our last appointment? If so, please list.

DURING THE PAST 2 MONTHS:

Do you drink distilled water regularly?	
Where does your drinking water come from? (Well, city, bottled)	
Do you have a wireless router in your house?	
Do you use tobacco currently? Type? Were you previously a smoker? How much?	
Do you have any major scars on your body?	
Do you have bloating/gas?	
Do you have heartburn?	
Do you have at least one bowel movement a day?	
How long does it take to fall asleep?	
How many times during the night do you wake to use the restroom? Do you fall back to sleep easily?	
What time do you generally go to bed?	
What time do you generally wake up?	
Do you sleep on a memory foam mattress or pillow?	
Do you have body piercings? How many? Where?	
How many 8 oz. cups of caffeinated drinks to you consume a day? (Coffee, tea, soda, etc.)	
Do you get dizzy if you stand too quickly?	
How many headaches a week do you have?	
How many meals do you eat at a restaurant or take-out restaurant a week?	
Do you have a "sweet tooth?" □Yes □No	
Do you use a microwave? How often?	
Do you chew gum? What kind? How often?	
Do you live West of Kalispell? (Kila area?)	
How would you rate your energy on a scale of 1-10, with 10 being very good?	
How many pills of pain relievers do you take a week? (Tylenol, Ibuprofen, Aleve, aspirin or similar)	
Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) and health and/or life threatening activities (e.g. fireman, etc.)?	
How many times in the **past 2 years** have you been on antibiotics, for any reason?	
How many times in your **lifetime** have you been on antibiotics?	

Patient's/Guardian's Signature:_____ **Date:** _____