

Patient Name: _____

Birthdate: _____

Address: _____

Home Phone: _____

Work Phone: _____

Pharmacy: _____

Pharmacy Phone: _____

Employer: _____

Marital Status: S M D W

Spouse's Name: _____ Spouse's DOB: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work phone: _____

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder
Name: _____

Policy Holder
DOB: _____

Group # : _____

Contract #: _____

SECONDARY INSURANCE

Policy Holder Name:

Policy Holder
DOB: _____

Group # : _____

Contract #: _____

ADDITIONAL INSURANCE

What is your biggest health concern at this time?

Please give me as much information as possible including how long you've had the problem, if you've seen a physician regarding the problem and what you've tried to make it better.

What are your goals with your naturopathic consultation?

Are you currently taking any medications AND/OR supplements? Please give doses and how often you take them.

Do you have any medication, food or other allergies? Please list all.

How is your energy?

What time of day do you feel the most tired?

Diet and Lifestyle

Typical Breakfast

Typical Lunch

Typical Dinner

Snacks

What are your favorite foods to eat?

Do you drink water? Yes No If yes, approximately how many oz per day (1 glass = approx. 8 oz)?

Do you exercise? Yes No If yes, what type and how many hours per week?

Do you drink coffee or soda? Yes No If yes, how many oz per day?

Do you drink alcohol now or in the past? Yes No If yes, how many drinks per week and what type of alcohol?

Do you smoke cigarettes now or in the past? Yes No If yes how many years and how many packs per day?

Social History

Are you currently married , single , divorced or widowed ?

What is your highest level of education?

What are your hobbies?

Do you have any pets in your home? Yes No What kinds of pets and how many?

Where have you traveled?

How many hours a week do you usually drive?

Where were you born?

What languages do you speak?

What illness did your mother have?

What illness did your father have?

What illness do your brothers and sisters have?

What illness do your children have?

It is very important that we get an idea of how your whole body functions in order to understand why you are sick. Please fill out the following form to the best of your ability.

General	YES	NO	PAST
Recent change in weight? If yes, increase or decrease and how many pounds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Digestion	YES	NO	PAST
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sores in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Urinary System	YES	NO	PAST
Frequent bladder or kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy or dribbling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night time urination If yes, how many times? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flatulence (farting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
# of bowel movements per day _____			
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undigested food in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in groin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last endoscopy _____			
Date of last colonoscopy _____			
Past or current hepatitis If yes, which type? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular **YES** **NO** **PAST**

Chest Pain at rest

Chest pain with exercise

Palpitations

Hypertension

History of heart attack, stroke,
congestive heart failure,
rheumatic fever? If yes please explain.

Varicose veins

History of blood clot
If yes, where?

Easy bruising or bleeding

Legs/feet swell at day's end

Thrombophlebitis

Mood **YES** **NO** **PAST**

Depression

Anxiety

Other psychiatric disorder

Thoughts of suicide

History of abuse

Current abuse

Would you like us to discuss your safety at home today?

Appetite **YES** **NO** **PAST**

Increased or decreased

Any cravings

Respiratory **YES** **NO** **PAST**

Sores in nose

Shortness of breath

If yes, what causes it?

Cough

If yes, is it productive?
If yes, what color?

Seasonal allergies

Household allergies

Frequent infections

Sinus pain/infections

Asthma/wheezing

Difficulty breathing
lying down

Emphysema

Bloody nose

Sleep **YES** **NO** **PAST**

Trouble falling asleep

Trouble staying asleep?

Avg. # of hours of sleep per night?

Average bedtime? _____

Wake feeling refreshed?

Head and Neck **YES** **NO** **PAST**History of glaucoma or cataracts Eye pain Dry eyes Itchy eyes Frequent headaches Vertigo Nasal congestion History of goiter Difficulty hearing Ear pain Lumps in neck Corrective lenses Light bother your eyes Jaw or tongue tire with chewing Hoarseness Nose bleeds Double vision Ringing in ears Temples or scalp tender to touch

Blood **YES** **NO** **PAST**Easy bruising Abnormal bleeding Hemophilia **Skin** **YES** **NO** **PAST**Dry skin Acne Rashes If yes, where? Lumps Color change Hives Rash from sun Yellow skin Excessive hair loss Non healing sores Fingers turn white in cold

Immune System **YES** **NO** **PAST**Frequent infections Risk for HIV

Endocrine **YES** **NO** **PAST**Heat intolerance Cold intolerance Increased Thirst Hair thinning Hair getting coarser Eyebrows thinning

Musculoskeletal	YES	NO	PAST
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning stiffness How many min/ hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Past traumatic injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle aching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff after being still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fractures Please list all.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Males Only	YES	NO	PAST
Testicular pain or lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge of sores on penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Female Only	YES	NO	PAST
Irregular menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breakthrough bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in arm pits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of sexual transmitted illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding after menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of last menstrual period _____

Length of cycle _____

of days of bleeding _____

Date of last Pap _____

Number of pregnancies _____

Number of miscarriages _____

Number of abortions _____

Number of children weighing under 5lbs 6oz
at birth _____

Nervous system

YES NO PAST

Seizures

Weakness

Paralysis

Numbness

Tingling

Tremors

Sense of internal trembling

Memory loss

Twitches

Hallucinations

Paranoia

Passing out

Room spinning

Head swimming

Other

Any current or past history of cancer
If yes, what type

Any past surgeries or illnesses that we have missed?

Is there anything you would like to add?