Name _____ Date of Birth _____ Gender _____

List, in order of importance, your goals for working with your physician:

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

Please list your allergies and <u>what happens when you are exposed to the allergen</u>:

Drug Allergies:_____

Food Allergies:_____

Environmental Allergies:_____

<u>Family History</u>

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	_____	_____	_____	_____	_____	_____
Age when died:	_____	_____	_____	_____	_____	_____
Reason for death:	_____	_____	_____	_____	_____	_____
Cancer type:	_____	_____	_____	_____	_____	_____
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

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

Please note when and/or why you have had or were diagnosed with any of the following:

X-Rays:_____ MRI/CAT Scan: _____

Ultrasounds: _____ Accidents: _____

TB Test: _____ HCV: _____

HIV: _____ Flu Shot: _____

Name _____ Date of Birth _____ Gender _____

Last Dental Visit: _____ Last eye exam: _____

Did you have the following Disease **(D),** Been Vaccinated **(V),** or Neither **(N):**

Measles	**D V N**	**Hemophilia**	**D V N**	**Rubella**	**D V N**
Mumps	**D V N**	**Chicken Pox**	**D V N**	**Tetanus**	**D V N**
Hep B	**D V N**	**Whooping Cough**	**D V N**	**Rubeola**	**D V N**
HIB	**D V N**				

Any vaccination reactions? _____

List **Y**es **(Y)**, **N**o **(N),** or **P**ast **(P)** regarding use of the following:

Antacids: Y N P **Steroids: Y N P** **Coffee: Y N P** **Cups per day if Yes:** _____

Analgesics: Y N P **Laxatives: Y N P** **Smoking: Y N P** **Packs per day & number of years:** _____

Soda Pop: Y N P **Ounces or cans per day if Yes:** _____

Alcohol: Y N P **How often & how much if Yes:** _____

Any Alcohol Addiction: Y N P **Any Alcohol Treatment: Y N P**

Recreational Drugs: Y N P **Any Drug Addictions: Y N P** **Any Drug Treatment: Y N P**

List all Prescription Medicines & Supplements/Herbs that you are taking and include dosage if known:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Present Weight: _____ Height: _____ Weight one year ago: _____

Maximum weight and when: _____ Minimum weight as adult & when: _____

Any weight questions or concerns?

_____

Name _____ Date of Birth _____ Gender _____

Regarding the next long section: Please circle **(Y)** if you currently have the problem, **(N)** if you've never had the problem and **(P)** if you had the problem in the past.

Good Energy: Y N P Fatigue: Y N P Average Energy Level (Low) 1 2 3 4 5 6 7 8 9 10 (High)

If you have fatigue when is it the worst? _____

If you have fatigue, can you do what you need to during the day? YES NO

SKIN

Rash:	**Y N P**	Color Change:	**Y N P**
Hives:	**Y N P**	Lump:	**Y N P**
Psoriasis/eczema:	**Y N P**	Itchy:	**Y N P**
Dry:	**Y N P**	Warts/moles:	**Y N P**
Cancer:	**Y N P**	Perspiration:	**Y N P**

HEAD

Headache:	**Y N P**	Migraine:	**Y N P**
Dandruff:	**Y N P**	Head Injury:	**Y N P**
Oil/Dry Hair:	**Y N P**	Hair Loss:	**Y N P**

NOSE

Frequent Colds:	**Y N P**	Nosebleeds:	**Y N P**
Congestion:	**Y N P**	Post Nasal Drip:	**Y N P**
Polyps:	**Y N P**	Seasonal Allergies:	**Y N P**

EYES

Dry/Watery:	**Y N P**	Blurry Vision:	**Y N P**
Double Vision:	**Y N P**	Cataracts:	**Y N P**
Glaucoma:	**Y N P**	Styes:	**Y N P**
Strain:	**Y N P**	Discharge:	**Y N P**
Itchy:	**Y N P**	Dark Under Eyelid:	**Y N P**

MOUTH/THROAT

Canker Sores:	**Y N P**	Cold Sores:	**Y N P**
Sore Throat:	**Y N P**	Gum Disease:	**Y N P**
Dentures:	**Y N P**	Cavities:	**Y N P**
Loss of Taste:	**Y N P**	Hoarseness:	**Y N P**

Naturopathic Clinic

Name _____ Date of Birth _____ Gender _____

NECK

Stiffness:	**Y N P**	Swollen Glands:	**Y N P**
Full Movement:	**Y N P**	Tension:	**Y N P**

RESPIRATORY

Cough:	**Y N P**	TB:	**Y N P**
Shortness of breath w/exertion:	**Y N P**	Bronchitis:	**Y N P**
Shortness of breath sitting:	**Y N P**	Pneumonia:	**Y N P**
Shortness of breath lying:	**Y N P**	Asthma:	**Y N P**
Wheezing:	**Y N P**	Painful breathing:	**Y N P**

CARDIOVASCULAR

High Blood Pressure:	**Y N P**	Rheumatic Fever:	**Y N P**
Low Blood Pressure:	**Y N P**	Murmurs:	**Y N P**
Arrhythmias:	**Y N P**	Palpitations:	**Y N P**
Edema:	**Y N P**	Chest Pain:	**Y N P**

URINARY TRACT

Incontinence:	**Y N P**	Pain w/Urination:	**Y N P**
Frequent Infections:	**Y N P**	Kidney Stones:	**Y N P**
Urgency:	**Y N P**	Discharge/Blood:	**Y N P**

GASTROINTESTINAL

Heartburn:	**Y N P**	Bowel Movement Freq:	
Indigestion:	**Y N P**	Recent BM Change:	**Y N P**
Bloating:	**Y N P**	Diarrhea/Constipation:	**Y N P**
Nausea:	**Y N P**	Hemorrhoids:	**Y N P**
Vomiting:	**Y N P**	Gall Bladder Disease:	**Y N P**
Change In Appetite:	**Y N P**	Liver Disease:	**Y N P**
Pancreatitis:	**Y N P**	Ulcer:	**Y N P**

MALE

Testicular pain/swelling:	**Y N P**	Sexually Active:	**Y N P**
Hernia:	**Y N P**	S.T.D.:	**Y N P**
Discharge:	**Y N P**	Prostate Disease/Symptoms:	**Y N P**
Impotency:	**Y N P**	Sexual Orientation:	**Hetero Homo Bi**

Naturopathic Clinic

Name _____ Date of Birth _____ Gender _____

FEMALE

Age Period Began:		How Often Period Occurs:	
How long period lasts:		Heavy menstrual bleeding:	**Y N P**
Menstrual cramping:	**Y N P**	Menstrual Pain:	**Y N P**
PMS:	**Y N P**	Food cravings:	**Y N P**
Times Pregnant:		How many births:	
Miscarriages:		Abortions:	
Last Pap Smear:		Diagnosis:	
Any abnormal paps:	**Y N P**	When was abnormal:	
Menopausal since what age:		Use of hormones:	**Y N P**
Type of hormones used:		Healthy libido:	**Y N P**
Dry vagina:	**Y N P**	Sexually Active:	**Y N P**
Pain w/intercourse:	**Y N P**	Vaginitis:	**Y N P**
S.T.D.:	**Y N P**	Mammography: If Yes, what were results?	**Y N P**
Dexa Scan: If yes, what were results?	**Y N P**	Sexual Orientation:	**Hetero Homo Bi**

List any birth control used, age used and length of time used: _____

_____

MUSCULOSKELETAL

Weakness:	**Y N P**	Arthritis:	**Y N P**
Stiffness:	**Y N P**	Leg Cramps:	**Y N P**
Tremors:	**Y N P**	Pain:	**Y N P**

NERVOUS

Paralysis:	**Y N P**	Sciatica:	**Y N P**
Tingling/numbness:	**Y N P**	Carpal tunnel syndrome:	**Y N P**
Seizures:	**Y N P**	Fainting:	**Y N P**

MENTAL/EMOTIONAL

Depression:	**Y N P**	Anger/irritability:	**Y N P**
Suicidal:	**Y N P**	High-strung/tense:	**Y N P**
Anxiety:	**Y N P**	Fear/Panic:	**Y N P**
Eating disorder:	**Y N P**	Psych Hospitalization:	**Y N P**

Name _____ Date of Birth _____ Gender _____

EXERCISE

How often do you exercise?

_____

What type of exercise?

_____

For how long?

_____

SLEEP

How many hours per night? _____

If you wake up frequently, what is the reason? _____

Nightmares:	**Y N P**	Wake Refreshed:	**Y N P**
Sleep Walk:	**Y N P**	Grind teeth:	**Y N P**
Must nap during the day:	**Y N P**	Snore:	**Y N P**

TOXIN EXPOSURE

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution?

_____

_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? YES NO

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

SOCIAL

Do you enjoy your job? _____ Hours worked per week: _____

Highest Level of Education: _____ Active spiritual practice: **Y N P**

Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: **Y N P**

If so, at what age and by whom: _____