

Patient Profile

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____ S.S.#: _____
Occupation: _____ Full or Part Time: _____
Employer: _____
Address: _____ City: _____ State: _____ Zip: _____
Education: _____ Referred by: _____
Are you: Married Separated Divorced Single Cohabiting
Live with: Spouse Partner Parents Relatives Friends Pets Alone
Next of kin (or emergency name): _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____

A NOTE TO OUR PATIENTS: Naturopathic, hollistic, and preventive health care require the physician to have a complete picture of the patient physically, mentally and emotionally. Please take the time to complete this health history questionnaire carefully and thoroughly.

CURRENT HEALTH CONDITION

When, where and from whom did you last receive medical or health care? _____

What are your most important health concerns?

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Which of the above problems are of most immediate concern? _____

Do you have any contagious diseases at this time: Yes No

If yes, what? _____

CURRENT MEDICATIONS

Do you take or use:

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Antacids | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Appetite supressants | <input type="checkbox"/> Nasal decongestants | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Hormones |

Please list any prescription or over-the-counter medications, vitamins or other supplements you are taking and dosages:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Speech difficulties	-	-	-		Loss of voice	-	-	-
				<u>Neck</u>				
Lumps	-	-	-		Swollen glands	-	-	-
Goiter	-	-	-		Pain or stiffness	-	-	-
				<u>Cardiovascular</u>				
Heart disease	-	-	-		Angina	-	-	-
High blood pressure	-	-	-		Low blood pressure	-	-	-
Blood clots	-	-	-		Fainting	-	-	-
Phlebitis	-	-	-		Palpitations	-	-	-
Rheumatic fever	-	-	-		Chest pain	-	-	-
Swelling in ankles	-	-	-		Heart murmurs	-	-	-
	YES	NEVER	PAST			YES	NEVER	PAST
				<u>Respiratory</u>				
Cough	-	-	-		Sputum production	-	-	-
Spitting up blood	-	-	-		Wheezing	-	-	-
Asthma	-	-	-		Bronchitis	-	-	-
Pneumonia	-	-	-		Pleurisy	-	-	-
Emphysema	-	-	-		Difficulty breathing	-	-	-
Pain on breathing	-	-	-		Shortness of breath	-	-	-
Tuberculosis	-	-	-		" " lying down	-	-	-
Night sweats	-	-	-		" " at night	-	-	-
				<u>Gastrointestinal</u>				
Trouble swallowing	-	-	-		Heartburn	-	-	-
Bad breath	-	-	-		Bad taste in mouth	-	-	-
Change in thirst	-	-	-		Change in appetite	-	-	-
Nausea	-	-	-		Vomiting	-	-	-
Vomiting blood	-	-	-		Constipation	-	-	-
Blood in stool	-	-	-		Diarrhea	-	-	-
Pain or cramps	-	-	-		Gall bladder disease	-	-	-
Belching	-	-	-		Ulcers	-	-	-
Passing gas	-	-	-		Hemorrhoids	-	-	-
Eating disorder	-	-	-		Distress from eating fats	-	-	-
Black stools	-	-	-		Jaundice	-	-	-
Liver disease	-	-	-		Bad body odor	-	-	-
Bowel movements:	How often	_____				Is this a change?	-	Yes
_ No								
				<u>Male reproduction</u>				
Hernias	-	-	-		Testicular mass	-	-	-
Testicular pain	-	-	-		Prostate disease	-	-	-
Discharge or sores	-	-	-		Herpes	-	-	-
Syphillis	-	-	-		Chlamydia	-	-	-
Gonorrhea	-	-	-		Condyloma	-	-	-
Premature ejaculation	-	-	-		Impotence	-	-	-
Vasectomy	-	-	-		Painful erections	-	-	-
Sexual orientation:	-	Heterosexual	-	Bisexual	-	Homosexual	-	Sexually active
	-							
				<u>Female reproduction/breasts</u>				
Age of first menses	_____				Cycles regular	-	-	-

Length of cycle _____				Bleeding between cycles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration of menses _____				Pain during intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clotting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list your symptoms:	_____			Type	_____		
	_____			Number of pregnancies	_____		
	_____			Number of live births	_____		
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of miscarriages	_____		
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of abortions	_____		
Difficulty conceiving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Condyloma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you do breast exams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast pain/tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual orientation:	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Homosexual	Sexually active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				<u>Urinary</u>			
Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequency at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many urinary infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems starting urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NEVER	PAST		YES	NEVER	PAST
				<u>Musculoskeletal</u>			
Joint pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<u>Blood/peripheral vascular</u>			
Easy bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep leg pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding from unusual places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<u>Emotional</u>			
Treated for emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Considered/attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<u>Neurologic</u>			
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<u>Endocrine</u>			
Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What hospitalizations or surgeries have you had? _____

ALLERGIES

Are you hypersensitive or allergic to:
Any drugs: _____

Any foods: _____

Any chemicals or environmental toxins: _____

What happens to you when you have an "allergy attack?" _____

What prior types of allergy testing have you had?

- Intradermal Scratch Blood IgG food Blood IgE inhalant/food Electroacupuncture
 Kinesiology Cytotoxic Food Intolerance None

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

LIFE STYLE

Main interests and hobbies: _____

Do you exercise? Yes No

If yes, what kind? _____

Do you have a religious or spiritual practice? Yes No

If yes, what kind? _____

Do you eat 3 meals a day? Yes No

If no, how many? _____

Do you average 6-8 hours sleep? Yes No

If no, how many? _____

Do you sleep well? Yes No

If no, what is the problem? _____

Do you awaken rested? Yes No

If no, what is the problem? _____

Do you enjoy your work? Yes No

If no, why not? _____

Do you spend time outside? Yes No

If yes, how much and in what form? _____

Do you watch television? Yes No

If yes, how much? _____

Do you read? Yes No

If yes, what and how much? _____

Do you take vacations? Yes No

If yes, how long and what kind? _____

Do you have a supportive relationship? Yes No

If no, what's wrong with it? _____

Do you have a history of abuse or trauma? Yes No

If yes, please describe: _____

CURRENT ILLNESS OR CONDITION

How does your condition affect you? _____

What do you think is happening? _____

Why? _____

What do you feel needs to happen for you to get better? _____

What do you enjoy most in life? _____

How much change are you willing to make at this time for improving your health? _____
