

Patient Profile

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____
Telephone: (Home) _____ (Work) _____
Occupation: _____ Referred by: _____
Are you: Married Separated Divorced Single Cohabiting
Live with: Spouse Partner Parents Relatives Friends Pets Alone

Next of kin (or emergency contact): _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____

A NOTE TO PATIENTS: Naturopathic, holistic, and preventive health care require that 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. Circle any unfamiliar words.

CURRENT HEALTH CONDITION

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

What are your most important health concerns?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
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 suppressants | <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. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FAMILY HISTORY

	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Children</u>
Ages (if living)	_____	_____	_____	_____	_____

Blood clots — — —
 Phlebitis — — —
 Rheumatic fever — — —
 Swelling in ankles — — —

Fainting — — —
 Palpitations — — —
 Chest pain — — —
 Heart murmurs — — —

Respiratory

Cough — — —
 Spitting up blood — — —
 Asthma — — —
 Pneumonia — — —
 Emphysema — — —
 Pain on breathing — — —
 Tuberculosis — — —
 Night sweats — — —

Sputum production — — —
 Wheezing — — —
 Bronchitis — — —
 Pleurisy — — —
 Difficulty breathing — — —
 Shortness of breath — — —
 " " lying down — — —
 " " at night — — —

Gastrointestinal

Trouble swallowing — — —
 Bad breath — — —
 Change in thirst — — —
 Nausea — — —
 Vomiting blood — — —
 Blood in stool — — —
 Pain or cramps — — —
 Belching — — —
 Passing gas — — —
 Eating disorder — — —
 Black stools — — —
 Liver disease — — —
 Bowel movements: How often _____

Heartburn — — —
 Bad taste in mouth — — —
 Change in appetite — — —
 Vomiting — — —
 Constipation — — —
 Diarrhea — — —
 Gall bladder disease — — —
 Ulcers — — —
 Hemorrhoids — — —
 Distress from eating fats _ — — —
 Jaundice — — —
 Bad body odor — — —
 Is this a change? _ Yes _ No

*****Male Reproduction*****

Hernias — — —
 Testicular pain — — —
 Discharge or sores — — —
 Syphilis — — —
 Gonorrhea — — —
 Premature ejaculation — — —
 Vasectomy — — —
 Sexual orientation: _ Heterosexual _ Bisexual _ Homosexual

Testicular mass — — —
 Prostate disease — — —
 Herpes — — —
 Chlamydia — — —
 Condyloma — — —
 Impotence — — —
 Painful erections — — —
 Sexually active — — —

*****Female Reproduction/Breasts*****

Age of first period _____
 Length of cycle _____
 Duration of period _____
 Painful periods — — —
 PMS — — —
 If yes, please list your symptoms:

 Endometriosis — — —
 Ovarian cysts — — —
 Difficulty conceiving — — —
 Cervical dysplasia — — —
 Sexual difficulties — — —

Cycles regular — — —
 Bleeding between cycles — — —
 Pain during intercourse — — —
 Clotting — — —
 Birth control — — —
 Type _____
 Number of pregnancies _____
 Number of live births _____
 Number of miscarriages _____
 Number of abortions _____
 Menopausal symptoms — — —
 Abnormal PAP — — —
 Vaginal discharge — — —

YES NEVER PAST

YES NEVER PAST

Female Reproduction/Breasts (continued)

Pelvic pain — — —
 Gonorrhea — — —
 Herpes — — —

Chlamydia — — —
 Condyloma — — —
 Syphilis — — —

Do you do breast exams	—	—	—	Breast pain/tenderness	—	—	—
Breast lumps	—	—	—	Nipple discharge	—	—	—
Sexual orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Homosexual				Sexually active	—	—	—

Urinary

Pain on urination	—	—	—	Increased frequency	—	—	—
Frequency at night	—	—	—	Inability to hold urine	—	—	—
Many urinary infections	—	—	—	Problems starting urine	—	—	—
Blood in urine	—	—	—	Kidney stones	—	—	—

Musculoskeletal

Joint pain or stiffness	—	—	—	Arthritis	—	—	—
Broken bones	—	—	—	Weakness	—	—	—
Muscle spasms or cramps	—	—	—	Back pain	—	—	—

Blood/Peripheral Vascular

Easy bleeding/bruising	—	—	—	Anemia	—	—	—
Deep leg pain	—	—	—	Cold hands/feet	—	—	—
Varicose veins	—	—	—	Thrombophlebitis	—	—	—
Fluid retention	—	—	—	Bleeding from unusual places	—	—	—

Emotional

Treated for emotional problems	—	—	—	Anxiety/nervousness	—	—	—
Mood swings	—	—	—	Depression	—	—	—
Considered/attempted suicide	—	—	—	Tension	—	—	—
Excessive worry	—	—	—	Panic attacks	—	—	—
Ever treated for alcoholism	—	—	—	Ever treated for drug dependence	<input type="checkbox"/>	—	—

Neurological

Seizures/epilepsy	—	—	—	Paralysis	—	—	—
Muscle weakness	—	—	—	Numbness or tingling	—	—	—
Loss of memory	—	—	—	Easily stressed	—	—	—
Vertigo or dizziness	—	—	—	Loss of balance	—	—	—

Endocrine

Hypothyroid	—	—	—	Heat/cold intolerance	—	—	—
Hypoglycemia	—	—	—	Diabetes	—	—	—
Excessive thirst	—	—	—	Excessive hunger	—	—	—
Fatigue	—	—	—	Seasonal depression	—	—	—
Unexplained weight loss/gain	—	—	—	Change in sexual desire	—	—	—

Immune

Vaccinations	—	—	—	Reactions to vaccinations	—	—	—
Chronic fatigue syndrome	—	—	—	Chronic infections	—	—	—
Chronically swollen glands	—	—	—	Slow wound healing	—	—	—

Skin

Rashes	—	—	—	Eczema/hives	—	—	—
Acne/boils	—	—	—	Itching	—	—	—
Color changes	—	—	—	Hair loss	—	—	—
Lumps	—	—	—	Warts	—	—	—

YES NEVER PAST

YES NEVER PAST

Habits

Use alcoholic beverages	—	—	—			
If yes, list types and amounts:	_____					

Use recreational drugs	—	—	—			
If yes, list types and amounts:	_____					

Smoke tobacco products	—	—	—	Chew tobacco products	—	—	—
If yes, list types and amounts: _____							
Drink coffee	—	—	—				
If yes, amount: _____							
Drink black tea	—	—	—	Drink cola	—	—	—
Eat out often	—	—	—	Go on diets often	—	—	—
Eat excessive sugar	—	—	—	Eat excessive salt	—	—	—

GENERAL INFORMATION

Weight: _____ lbs.	Weight 1 year ago: _____ lbs.
Maximum weight: _____ lbs.	When: _____
Height: _____ ft. _____ in.	
When is your energy the best during the day?	Worst? _____

X-RAYS AND SPECIAL STUDIES

Electrocardiogram (EKG) Electroencephalogram (EEG) Intravenous Pyelogram (IVP)

What x-rays, CAT scans, or other studies have you had? _____

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had? _____

ALLERGIES

Are you hypersensitive or allergic to:
 Any drugs: _____

Any foods: _____

Any chemicals or environmental toxins: _____

If you have "allergy attacks", what happens to you?" _____

What, if any, prior types of allergy testing have you had?

<input type="checkbox"/> Intradermal	<input type="checkbox"/> Scratch	<input type="checkbox"/> Blood IgG food	<input type="checkbox"/> Blood IgE inhalant/food	<input type="checkbox"/> Electroacupuncture
<input type="checkbox"/> Kinesiology	<input type="checkbox"/> Cytotoxic	<input type="checkbox"/> Food Intolerance	<input type="checkbox"/> None	

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Amount of water daily: _____

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 sleep well? Yes No

If no, what is the problem? _____

Do you average 6-8 hours sleep? Yes No

If no, how many? _____

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 take vacations? Yes No
If yes, how long and what kind? _____
Do you have a supportive relationship? Yes No
If no, what needs to change? _____

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? _____

THANK YOU FOR YOUR THOROUGH ANSWERS. I LOOK FORWARD TO HELPING YOU REACH YOUR HEALTHCARE GOALS