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## PERSONAL INFORMATION

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_ # OF CHILDREN \_\_\_\_\_  
HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ PREGNANT NOW \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
SPOUSE/GUARDIAN \_\_\_\_\_ SPOUSE'S OCCUPATION \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
WHO MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

## EMERGENCY NOTIFICATION

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

## CURRENT HEALTH CONCERNS

LIST HEALTH CONCERNS IN ORDER OF IMPORTANCE:

	Rate Severity 1 = Mild 10 = Worst Imaginable	Date started, for how long?	If you had the condition before, when?	What irritates the condition?	Worse at certain times of day?
1.					
2.					
3.					
4.					
5.					

WHAT HAVE YOU DONE FOR THESE CONDITIONS? WAS IT OF BENEFIT?

\_\_\_\_\_  
\_\_\_\_\_

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING ACTIVITIES

WORK \_\_\_\_\_ SLEEP \_\_\_\_\_ DAILY ROUTINE \_\_\_\_\_ SPORTS/EXERCISE \_\_\_\_\_ OTHER \_\_\_\_\_

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION

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PLEASE LIST OTHER DOCTORS YOU HAVE SEEN FOR THIS CONDITION

1. NAME/CITY \_\_\_\_\_  
 TYPE OF DOCTOR \_\_\_\_\_ DATES SEEN \_\_\_\_\_  
 DIAGNOSIS \_\_\_\_\_ TREATMENT \_\_\_\_\_  
 RESULTS \_\_\_\_\_

2. NAME/CITY \_\_\_\_\_  
 TYPE OF DOCTOR \_\_\_\_\_ DATES SEEN \_\_\_\_\_  
 DIAGNOSIS \_\_\_\_\_ TREATMENT \_\_\_\_\_  
 RESULTS \_\_\_\_\_

PLEASE LIST ANY SURGERIES YOU HAVE HAD

1. TYPE: \_\_\_\_\_ DATE: \_\_\_\_\_ DOCTOR: \_\_\_\_\_  
 2. TYPE: \_\_\_\_\_ DATE: \_\_\_\_\_ DOCTOR: \_\_\_\_\_  
 3. TYPE: \_\_\_\_\_ DATE: \_\_\_\_\_ DOCTOR: \_\_\_\_\_

PLEASE LIST ANY ACCIDENTS AND/OR INJURIES: AUTO, WORK-RELATED, OR OTHER

1. TYPE: \_\_\_\_\_ DATE: \_\_\_\_\_ HOSPITALIZED: \_\_\_\_ YES \_\_\_\_ NO  
 2. TYPE: \_\_\_\_\_ DATE: \_\_\_\_\_ HOSPITALIZED: \_\_\_\_ YES \_\_\_\_ NO  
 3. TYPE: \_\_\_\_\_ DATE: \_\_\_\_\_ HOSPITALIZED: \_\_\_\_ YES \_\_\_\_ NO

**PREVIOUS NATUROPATHIC EXPERIENCE**

HAVE YOU EVER CONSULTED WITH A NATUROPATH? \_\_\_\_\_ IF SO, WHO? \_\_\_\_\_  
 WERE YOU HAPPY WITH THE RESULTS OF YOUR VISIT(S)? \_\_\_\_\_

WHAT THERAPIES WERE USED? (NUTRITION CONSULTATION, HERBS, HOMEOPATHY...)

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**HABITS**

<input type="checkbox"/> <b>Alcohol:</b> Type _____ Amount _____	<input type="checkbox"/> <b>Other</b> _____	Daytime drowsiness _____
<input type="checkbox"/> <b>Smoking:</b> Packs daily _____ How long _____ Interested in stopping? _____	<input type="checkbox"/> <b>Sleep:</b> Difficulty falling asleep _____ Continuity disturbances _____	Other _____
<input type="checkbox"/> <b>Caffeine:</b> Coffee, soda or tea, cups daily _____	Hours of sleep per night _____	<input type="checkbox"/> <b>Exercise routine:</b> _____ _____
		How often _____

**MEDICINE / SUPPLEMENTS**

PLEASE LIST ALL DRUGS YOU CURRENTLY TAKE OR HAVE TAKEN IN THE PAST 6 MONTHS

NAME \_\_\_\_\_ DOSAGE \_\_\_\_\_ FOR WHAT \_\_\_\_\_  
 NAME \_\_\_\_\_ DOSAGE \_\_\_\_\_ FOR WHAT \_\_\_\_\_  
 NAME \_\_\_\_\_ DOSAGE \_\_\_\_\_ FOR WHAT \_\_\_\_\_  
 NAME \_\_\_\_\_ DOSAGE \_\_\_\_\_ FOR WHAT \_\_\_\_\_

PLEASE LIST ALL NUTRITIONAL SUPPLEMENTS, VITAMINS, AND HOMEOPATHIC REMEDIES YOU PRESENTLY TAKE

NAME \_\_\_\_\_ FOR WHAT \_\_\_\_\_  
 NAME \_\_\_\_\_ FOR WHAT \_\_\_\_\_  
 NAME \_\_\_\_\_ FOR WHAT \_\_\_\_\_  
 NAME \_\_\_\_\_ FOR WHAT \_\_\_\_\_  
 NAME \_\_\_\_\_ FOR WHAT \_\_\_\_\_

**DIET**

DO YOU EAT BREAKFAST EVERY DAY? IF SO, WHAT DO YOU EAT? \_\_\_\_\_  
 HOW MANY MEALS PER DAY DO YOU EAT? \_\_\_\_\_  
 HOW MANY FRUIT SERVINGS DO YOU CONSUME PER DAY? \_\_\_\_\_ VEGETABLES? \_\_\_\_\_  
 DO YOU HAVE A SPECIAL DIET? IF SO, WHAT IS IT? \_\_\_\_\_  
 DO YOU HAVE ANY FOOD ALLERGIES? IF SO, WHAT ARE THEY? \_\_\_\_\_  
 HOW IS YOUR PHYSICAL HEALTH? (CIRCLE ONE) EXCELLENT GOOD FAIR POOR GETTING WORSE

**MEDICAL HISTORY**

**Do you have now or have you had within the past year:** Please put a check in the column of the correct response beside each question. N= Never O= Occasionally (Few times per year) F= Frequently (Monthly)

Weakness or Paralysis	N	O	F	Last eye exam _____				Fluttering of Heart	N	O	F
Tire easily	N	O	F	Ringing in Ears	N	O	F	Leg cramps	N	O	F
Weight Change	N	O	F	Ear pain	N	O	F	Difficulty Swallowing	N	O	F
Change in Appetite	N	O	F	Hearing loss	N	O	F	Heartburn	N	O	F
Sensitivity to Cold or heat	N	O	F	Frequent nose Bleeds	N	O	F	Frequent Belching	N	O	F
Night sweats	N	O	F	Frequent colds	N	O	F	Abdominal Cramping	N	O	F
Hot flashes	N	O	F	Sinus problems	N	O	F	Nausea	N	O	F
Skin problems	N	O	F	Loss of smell	N	O	F	Vomiting	N	O	F
Change in nails Or hair	N	O	F	Sore throat	N	O	F	Vomited or Coughed up			
Headaches	N	O	F	Sore tongue or gums	N	O	F	Blood	N	O	F
Easy bleeding	N	O	F	Chronic cough	N	O	F	Chronic Diarrhea	N	O	F
Easy bruising	N	O	F	Shortness of Breath	N	O	F	Chronic Constipation	N	O	F
Double vision	N	O	F	Chest pain or Discomfort	N	O	F	Rectal bleeding	N	O	F
Blurred vision	N	O	F	Purple fingers Or lips	N	O	F	Dark urine	N	O	F
Eye pain	N	O	F	Difficulty Breathing	N	O	F	Frequent (day) Urination	N	O	F
Do you wear Glasses or Contacts	N	O	F	Palpitations or							

Frequent (night) Urination	N	O	F	Depression	N	O	F	Pain with intercourse	N	O	F
Increase in Thirst	N	O	F	Memory loss	N	O	F	Do you bleed or spot between periods	N	O	F
Painful Urination	N	O	F	Poor coordination	N	O	F	Do you have pain or cramps?	N	O	F
Leakage of Urine	N	O	F	Dizziness	N	O	F	Date of last mammogram	_____		
Blood in urine	N	O	F	Fainting	N	O	F	Vaginal itching	N	O	F
Lack of sex drive	N	O	F	<u>Men only:</u> Discharge from Penis	N	O	F	Type of birth control used	_____		
Backaches	N	O	F	Pain or lump in testicles	N	O	F	Number of pregnancies	_____		
Joint pain or stiffness	N	O	F	Impotence	N	O	F	Number of full term births	_____		
Swollen joints	N	O	F	<u>Women only:</u> Age period began	_____			Number of preterm Births	_____		
Muscle cramps or spasms	N	O	F	# of days period lasts	_____						
Sleeplessness	N	O	F	Days between periods	_____						
Seizures	N	O	F	Is your flow heavy?	N	O	F				
				Date of last period	_____						
				Date of last pelvic	_____						

**FAMILY HISTORY**

**PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:**

**HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:**

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	_____	_____	_____	BLOOD DISEASE GLAUCOMA EPILEPSY	_____ _____ _____
SPOUSE				ARTHRITIS BACK PROBLEMS	
CHILDREN	_____	_____	_____	HEART DISEASE GOUT HIGH BLOOD PRESSURE	_____ _____ _____

WHAT DO YOU HOPE TO ACCOMPLISH FROM OUR TIME TOGETHER? HOW LONG DO YOU EXPECT IT TO TAKE TO ACCOMPLISH THAT GOAL?

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Naturopath's office of any changes in my medical status. I understand this consultation is not meant to diagnose, treat or cure any disease or problem I may be experiencing.

Signature \_\_\_\_\_ Date \_\_\_\_\_