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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

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...)

HABITS

<input type="checkbox"/> Alcohol: Type _____ Amount _____	<input type="checkbox"/> Other _____	Daytime drowsiness _____
<input type="checkbox"/> Smoking: Packs daily _____ How long _____ Interested in stopping? _____	<input type="checkbox"/> Sleep: Difficulty falling asleep _____ Continuity disturbances _____	Other _____
<input type="checkbox"/> Caffeine: Coffee, soda or tea, cups daily _____	Hours of sleep per night _____	<input type="checkbox"/> Exercise routine: _____ _____ 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	Ringing in Ears	N	O	F	Leg cramps	N	O	F
Tire easily	N	O	F	Ear pain	N	O	F	Difficulty Swallowing	N	O	F
Weight Change	N	O	F	Hearing loss	N	O	F	Heartburn	N	O	F
Change in Appetite	N	O	F	Frequent nose Bleeds	N	O	F	Frequent Belching	N	O	F
Sensitivity to Cold or heat	N	O	F	Frequent colds	N	O	F	Abdominal Cramping	N	O	F
Night sweats	N	O	F	Sinus problems	N	O	F	Nausea	N	O	F
Hot flashes	N	O	F	Loss of smell	N	O	F	Vomiting	N	O	F
Skin problems	N	O	F	Sore throat	N	O	F	Vomited or Coughed up			
Change in nails or hair	N	O	F	Sore tongue	N	O	F	Blood	N	O	F
Headaches	N	O	F	or gums	N	O	F	Chronic Diarrhea	N	O	F
Easy bleeding	N	O	F	Chronic cough	N	O	F	Chronic Constipation	N	O	F
Easy bruising	N	O	F	Shortness of Breath	N	O	F	Rectal bleeding	N	O	F
Double vision	N	O	F	Chest pain or Discomfort	N	O	F	Dark urine	N	O	F
Blurred vision	N	O	F	Purple fingers Or lips	N	O	F	Frequent (day) Urination	N	O	F
Eye pain	N	O	F	Difficulty Breathing	N	O	F	Frequent (night) Urination	N	O	F
Do you wear Glasses or Contacts	N	O	F	Palpitations or Fluttering of Heart	N	O	F				
Last eye exam	_____										

Increase in Thirst N O F
 Painful Urination N O F
 Leakage of Urine N O F
 Blood in urine N O F
 Lack of sex drive N O F
 Backaches N O F
 Joint pain or stiffness N O F
 Swollen joints N O F
 Muscle cramps or spasms N O F
 Sleeplessness N O F
 Seizures N O F
 Depression N O F
 Memory loss N O F
 Dizziness N O F

Poor coordination N O F
 Fainting N O F

Men only:

Discharge from Penis N O F
 Pain or lump in testicles N O F
 Impotence N O F

Women only:

Age period began _____
 # of days period lasts _____
 Days between periods _____
 Is your flow heavy? N O F
 Date of last period _____
 Date of last pelvic _____

Pain with intercourse N O F
 Do you bleed or spot between periods N O F
 Do you have pain or cramps? N O F
 Date of last mammogram _____
 Vaginal itching N O F
 Type of birth control used _____
 Number of pregnancies _____
 Number of full term births _____
 Number of preterm Births _____

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 _____