Naturopathic Adult Health History Form

First name _____ Last name _____ Date _____

Age _____ Date of Birth _____Birth Sex:_____ Gender: _____ Pronouns: _____

Mobile Ph #_____Home Ph # _____

E-mail address _____

Is any other family member already seeing us? _____

Person(s) to reach in an emergency _____

Relationship(s) _____ Phone #'s_____

May we thank someone for referring you to us? _____

PROACTIVE HEALTH CARE IS ONLY POSSIBLE WHEN THE PROVIDER HAS A COMPLETE UNDERSTANDING OF THE PERSON MENTALLY, PHYSICALLY, AND EMOTIONALLY.

PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

PLEASE, PRINT!

Are you hypersensitive or allergic to:
Any drugs? Please name: _____
Any food? Please name: _____
Any environmental things? Please name: _____

Do you use smoke, vape, or use cannabis? ☐ Yes ☐ No ☐ Past If yes, or in the past, how many years? _____
If yes, or in the past, how many packs, cigarettes, cartridges, etc., per day or week? _____

Are you currently receiving healthcare for any reason? ☐ Yes ☐ No

If yes, from whom and where are they located? _____

For what reason(s)? _____

Do you have a primary care provider? If yes, please list name_____

What are the three, most important health problems or goals that you would like to address at your first visit?

1. _____

2. _____

3. _____

Do you have a diagnosed illness or disease that should be known as a part of your health history?

_____

Were you born via C-section? ☐ Yes ☐ No Were you breastfed? ☐ Yes ☐ No

Have you ever lived or worked in a water-damaged or moldy building? ☐ Yes ☐ No

Have you ever had food poisoning or traveler's diarrhea? ☐ Yes ☐ No

How many rounds of antibiotics have you taken in the last 10 yrs? _____ During childhood? _____

Have you ever taken the following medications for more than 2 weeks?_____

Opiates ☐ Muscle Relaxants ☐ PPI/Antacids ☐ Laxatives ☐ Steroid drugs ☐

PLEASE LIST ALL VITAMINS, HERBS, SUPPLEMENTS, PRESCRIPTION MEDICATIONS, AND OVER THE COUNTER MEDICATIONS YOU ARE TAKING.
Please include full name of product, milligram amounts, how often taken, etc.
PLEASE BRING IN THE BOTTLES or EMAIL US clear photos of the front and back labels of EACH bottle

_____

_____

_____

_____

_____

_____

_____

GENERAL

Weight today _____lbs. (or kilos) Maximum weight _____ lbs. (or kilos)

Weight one year ago? _____lbs. (or kilos) Desired weight _____lbs. (or kilos)

Height_____ when was this last checked? _____

ONCOLOGY PATIENTS, ONLY

What surgeries have you had for your condition and when?

_____

_____

Have you had or are you now receiving any chemotherapy (oral or IV), targeted therapy or immunotherapy treatment? If yes, which drugs, how many cycles, when was your last treatment, etc.?

_____

_____

_____

Have you had any radiation treatments of any type? Which body part(s)? Approximately how many treatments and when?

_____

_____

FOR ALL OTHER CONDITIONS

What surgeries have you had and when?

_____

_____

SOCIAL HISTORY

Are you: ☐ Single ☐ Married ☐ Divorced ☐ in a Significant Partnership ☐ Widowed

Do you live: ☐ Alone ☐ w/Spouse ☐ w/Children ☐ w/Partner ☐ w/Parent(s) ☐ w/ Roommates

Current or Former Occupation/profession _____

Hours per week _____ Are you retired? _____

Employer _____

In a typical week, how many times do you talk in person or on the telephone with family, friends, or neighbors?

_____

In a typical week, how often do you get together, in person, with friends, relatives, or neighbors?

_____

Do you belong to any social organizations, groups, churches, spiritual groups or do you volunteer?

_____

Main interests and hobbies: _____

SCREENINGS:

Date of last Physical Exam? _____ Colonoscopy? _____ Labs? _____
Males: Prostate Exam? _____
Females: Last PAP smear or pelvic exam? _____ Last mammogram? _____

FAMILY HISTORY

Please note if any of these diseases/problems are (or were) applicable to your parents, grandparents, uncles, aunts, or siblings.
Please note for whom it was a problem.

Cancer & Type

Diabetes

Heart Disease

High Blood Pressure

Strokes

Mental Illness

Are your parents, grandparents, siblings, and children all still living? _____
If not, please note their cause of death and at what age(s), if known?

_____

Typical Food Intake- we know it varies, but please give examples

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

EXERCISE

Do you exercise? ☐ YES ☐ NO ☐ PAST
If yes, what type of exercise _____

How often do you exercise? _____How many minutes per workout?
_____

For the following sections, please use this KEY:

Y= a condition you have now N= a condition you have never had P= had in the past

Do you average 7-8 hours of sleep? ☐Y☐N
Do you sleep well? ☐Y☐N
Do you awaken rested? ☐Y☐N
Do you have a supportive relationship? ☐Y☐N
Do you have a history of any abuse? ☐Y☐N☐P
Any major traumas? ☐Y☐N☐P
Do you eat 3 or more meals/day? ☐Y☐N
Do you eat out, often (4x/wk or more)? ☐Y☐N
Do you go on diets, often? ☐Y☐N
Do you drink any coffee? ☐Y☐N
Do you drink black tea? ☐Y☐N
Do you add salt to your food? ☐Y☐N

Do you enjoy your work? ☐Y ☐N ☐P
Take vacations? ☐Y ☐N ☐P
Spend time outside? ☐Y ☐N
Do you watch TV, YouTube, stream shows? ☐Y ☐N
For TV, YouTube, Streaming how many hrs./day? _____
Do you read regularly? ☐Y ☐N
How many hours/day? _____
Do you use alcoholic beverages? ☐Y ☐N ☐P
How much, how often? _____
Have you been treated for any addictions? ☐Y ☐N
Do you drink cola or other sodas/soft drinks? ☐Y ☐N
How many hrs./day for recreational "Screen time"? _____

Sexual orientation _____
Are you, currently, having sexual relations with a partner? ☐ Y ☐ N
Are there any sexual difficulties? _____
Birth control used? If yes, which type(s)? _____
Do you have children? Please list names, sex, and ages.
_____

Do you travel often for work? ☐ Y ☐ N
Do you travel to any undeveloped countries? List: _____
Are you exposed to any chemicals or occupational hazards as a part of your day or work?
_____

Do you have any pets? If so, please list type _____

HEAD

Do you have chronic headaches, migraines, head injury history, TMJ problems, etc.? PLEASE LIST
_____

EYES

Do you have impaired vision, visual disturbances, eye pain, "dry eye syndrome", excessive tearing, glaucoma, cataracts, macular degeneration, etc.? PLEASE LIST
_____

EARS

Do you have impaired hearing, ringing in your ears (tinnitus), ear pain, etc.? PLEASE LIST
_____

NOSE AND SINUSES

Do you suffer from frequent colds or sinus infections, nose bleeds, loss of smell, etc.? PLEASE LIST
_____

MOUTH AND THROAT

Do you have any issues with frequent sore throat/mouth/lips or tongue; hoarseness, teeth grinding, gum problems, dental problems, etc.? PLEASE LIST

_____

SEASONAL ALLERGIES

Do you have any seasonal allergy symptoms? What are your symptoms? What time of year? PLEASE LIST

_____

RESPIRATORY

Do you have any issues with a chronic cough, asthma, wheezing, shortness of breath? PLEASE LIST

_____

Have you been told you have COPD?

_____

Do you have a Tuberculosis history?

_____

CARDIOVASCULAR

Do you have a history of high cholesterol, heart attacks, blood clots, high blood pressure, chest pain, valvular problems, arrythmias, palpitations, etc.? PLEASE LIST

_____

BLOOD/PERIPHERAL VASCULAR

Do you have excessive bruising, easy bleeding, circulation problems, chronic anemia, etc.? PLEASE LIST

_____

GASTROINTESTINAL

Do you have any trouble with swallowing, nausea, vomiting, heartburn/acid reflux/GERD; a gastric ulcer history, excessive bloating, burping, flatulence; hemorrhoids, liver disease, etc.? PLEASE LIST

_____

HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT? _____

Are your stools well formed, hard, painful, loose, diarrhea or difficult to pass? Please describe.

_____

Do you have a lot of straining or pass any blood or mucus with bowel movements?

_____

BONES/BACK/NECK/JOINTS/MUSCLES

Do you have problems with joint pain, stiffness, arthritis, muscle cramps, muscle spasms, back pain, neck pain, etc.? PLEASE LIST

_____

Have you had a bone density scan? _____ If yes, when was the last one? _____
Do you have osteopenia or osteoporosis? _____

NEUROLOGY

Do you have a history of seizures, loss of consciousness, memory issues, muscle weakness, numbness or tingling; paralysis, vertigo/dizziness, neurological disorders? PLEASE LIST

_____

SKIN

Do you have issues with rashes, hives, eczema, acne, recurrent boils, unusual skin lesions/moles; hair loss? PLEASE LIST

_____

ENDOCRINE

Do you have hyper or hypothyroidism, diabetes Type I or II, pituitary problems, etc.? PLEASE LIST

_____

IMMUNE

Do you have a history of frequent infections, negative reactions to vaccinations, slow wound healing, etc.?

_____

URINARY/KIDNEY

Do you have pain with urination, inability to hold your urine, urinary frequency, frequent infections, a history of kidney stones; kidney disease, etc.? PLEASE LIST

_____

MALE REPRODUCTIVE SYSTEM

Do you have a history of hernias, testicular problems, prostates problems, sexually transmitted infections, ED?

_____

FEMALE REPRODUCTIVE SYSTEM

Age of first period? _____
Age/date of last period? _____
Day 1 of period to Day 1 of next period is _____days?
Are periods/cycles regular? ☐Y ☐ N
Duration of days for period bleeding? _____
Painful periods? ☐Y ☐ N
Heavy or excessive flow? ☐Y ☐ N
PMS symptoms? ☐Y ☐ N
If yes, what are your symptoms _____
Endometriosis history? ☐Y ☐ N
Ovarian cyst history? ☐Y ☐ N
Fibroid tumors ☐Y ☐ N

Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Abnormal PAP history? ☐Y ☐N ☐P
Cervical dysplasia? ☐Y ☐N ☐P
Sexually transmitted infections? ☐ Y ☐ N ☐P
Please list _____
Gynecological surgeries/procedures? _____
Menopausal symptoms? ☐Y ☐N
Please list _____
Do you perform breast self-exams? ☐ Y ☐N
Breast pain/tenderness/nipple discharge? ☐ Y ☐N

MENTAL / EMOTIONAL / PSYCHOLOGICAL

Do you have a diagnosed, mental health disorder?

_____

Do you have mood swings, depression, anxiety, get easily stressed?

_____

Have you ever considered or attempted suicide? _____ When? _____

SPELLS

Do you have any spells of anxiety, heart pounding, face flushing, weeping, irritability, excessive yawning, drowsiness, memory black-out, weakness, shakiness, chills, sweats, hot flashes, poor concentration, etc.?

_____

If yes, when do spells occur?

Before/after meals ☐ If hungry ☐ If upset ☐ Morning ☐ Afternoon ☐ Evening ☐ Other ☐

FINANCES

Please choose your difficulty for paying for basic expenses like food, housing, medical care, and utilities.

Very hard ☐
Hard ☐
Somewhat hard ☐
Not very hard ☐

VIOLENCE

Within the last year, have you been humiliated or abused by your partner or ex-partner? _____
Within the last year, have you been afraid of your partner or ex-partner? _____
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? _____
Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? _____

How do your current health conditions affect you?

_____

_____

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

_____

_____

What do you enjoy most in your life? _____

_____

How much change are you willing to make, currently, to improve your health?

_____

Is there anything else you would like to add?

_____

_____

_____

Welcome!

We are glad to serve you!