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Name _____ Age ____ D.O.B. _____ Date _____
Address _____ City _____ State ____ Zip _____
Parent or Guardian (or emergency name) _____
Telephone (Home) _____ (Work) _____ (Cell)_____
Is it OK to leave a message at these phone numbers? Home Y N Work Y N Cell Y N

NOTE: Naturopathic health care is only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Therefore, please complete this health questionnaire as thoroughly as possible.

What other health care are you presently receiving? _____
_____

What are your most significant health problems? List in order of importance.
1._____
_
2._____
3._____
_
4._____
_

What are your health goals?
1._____
_
2._____
_
3._____
_
4._____
_

PAST MEDICAL HISTORY

What childhood illnesses have you had?
Rubella (German 3 day measles)___ Measles (2 week)___ Mumps___ Chickenpox___ Roseola___
Whooping cough___ Rheumatic Fever___ Scarlet Fever___ Diphtheria___
Other_____

VACCINATIONS

___Chicken Pox ___Hepatitis B ___Hemophilus Influenza (HIB)
___Diphtheria ___Pertussis ___Measles/Mumps/Rubella (MMR)
___Polio ___Tetanus (not antitoxin) ___Pneumococcus
Other _____

HOSPITALIZATIONS

Type of illness or operation/procedure Date Hospital
_____ _____ _____
_____ _____ _____
_____ _____ _____

MEDICATIONS - List all drugs, vitamins, herbs and supplements being taken at present with dosage.

_____
_____
_____
_____

ALLERGIES

Are you allergic to any **medications**? Y N

If yes, please list _____

_____

What happens when you have an allergic reaction? _____

Are you allergic to any **foods**? Y N

If yes, please list_____

_____

What happens when you have an allergic reaction? _____

FAMILY HISTORY

Has any **Blood Relative** had any of the following:

____Anemia	____Bleeding (easily)	____Hay fever
____Arthritis	____Diabetes	____Seizures/Epilepsy
____Asthma	____Eczema	____Sickle Cell Anemia

Other (specify)_____

HEALTH HABITS:

How much water do you drink each day?_____

What are your primary interests or hobbies?_____

_____

_____

DIET

Number of meals eaten per day: 1 2 3 more than 3

List any foods you exclude from your diet._____

List any foods to which you have a bad reaction : _____

_____

SLEEP

Do you sleep well? Y N Do you wake rested? Y N How many hours do you sleep?_____

Do you have trouble falling asleep? Y N Do you sleep straight through the night? Y N

HEALTH HISTORY

Have you ever been diagnosed with or suffered from any of the following conditions?

(*) Please specify

___Allergies	___Cancer*_____	___Heart murmur*
___Anemia	___Candida (yeast)	___Hyperactive disorder
___Arthritis	___Colitis	___HIV
___Asthma	___Diabetes	___Kidney disease
___Attention deficit disorder	___Eczema	___Liver disease/jaundice
___Autism	___Epilepsy	___Multiple sclerosis
___Bleeding disorder	___Failure to thrive	___Pneumonia
___Cataracts	___Headache/migraines*	___Rheumatic fever

___Thyroid (hyper/hypo)*
Others (specify)_____

SYMPTOMS
(*) Please specify

____Pain in ears
____Ringing in ears
____Discharge in ears
____Hearing loss
____Recurrent ear infections
____Tympanostomy (tubes in ears)
____Dizziness
____Dry eyes, nose and/or mouth
____Eyelids swollen/puffy
____Poor eyesight: near/far (circle one)
____Nose bleeds
____Loss of sense of smell
____Sinus congestion
____Trouble swallowing
____Bad breath
____Bad taste in mouth
____Sore mouth or tongue
____Cold sores, blisters
____Receding/bleeding gums
_____Number of silver/mercury fillings
____Chronic sore throat
____Loss of voice
____Difficulty swallowing
____Recurrent strep throat
____Skin rough, dry, scaly, bumpy, itchy (circle)
____Rashes, warts, moles, cysts (circle)

Have any of these changed in size or color recently? _____
Would you like to have any of these removed? _____

____Light or dark patches of skin (circle)
____Nails: Color changes, ridges, pits, white spots (circle)
____Hives. List what causes them _____
_____
____Muscle/leg/toe cramps
____Joint pain/ stiffness/ swelling specify_____
____Arthritis
____Stiffness
____Pulse slow/irregular
____Daily cough
____Wheezing
____Chest congestion
____Chest pain when breathing
____Frequent/severe nausea
____Frequent vomiting
____Excessive belching, stomach cramps, colic
____Abdominal bloating/distention
____Stomach/abdominal pain
____Distress from fat or greasy foods
_____Frequency of bowel movements per day/per week*
____ Increased/decreased appetite
____Constipation
____Diarrhea
____Alternating constipation and diarrhea
____Indigestion/pain after eating a meal
____Heavy, full after eating
____Change in bowel movements
____Ulcer/colitis (circle)
____Blood in stools
____Stools: yellow, gray, green, foul odored, black, undigested food (circle)
____Severe headaches/migraines
____Seizures, convulsions
____Perspiration scant/excessive
____Burning on soles of feet or palms of hands (circle)
____Tremor (shaking, trembling)
____Lack of strength (body area)
____Paralysis
____Numbness/tingling in extremities
____Painful lymph nodes
____Swollen glands
____Unexplained fever
____Night sweats
____Easily fatigued
____Flushed, get hot easily
____Unexplained weight loss/gain
____Cold hands or feet
____Intolerant of hot/cold weather
____Weakness
____Increased thirst
____Low sugar tolerance
____Nervous, shaky with headaches relieved by food
____Irritable if late for a meal, miss meal or before breakfast
____Diet but fail to lose weight
____Eat but fail to gain weight
____Over/underweight
____Compulsive eating
____Anxiety
____Irritable/restless
____Decreased concentration and comprehension
____Excessive excitement
____Depression

____Despair/Discontent
____Shy, Timid
____Difficulty holding urine
____Blood in urine
____Repeated kidney or bladder infections (circle)
____Swelling, lumps and pain in testicles
____Frequent urination
____Painful urination
____Nipple discharge
____Discharge from vagina
____Vaginal itching/burning

Thank You For Your Cooperation, Patience and Thoroughness