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Patient Health History Questionnaire

Naturopathic healthcare is possible only when the physician completely understands the patient's physical, mental and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. Please answer all questions as completely as possible, and mark anything that you have a question about. And, welcome!

Patient's name: ____
(Last) (First) (Middle initial)

Mailing address: _____________________City:___________ State:_____ Zip:______
Physical address (if different): ____

E-mail address:______________________ Would you like to receive our e-mail newsletter? Y N
Phone: ____________________ ______________________ ____________________
(Home) (Work) (Other)
Date of birth: _________ Age: _________ Female or Male

Occupation: ________________________
(We collect social security numbers for the purpose of patient identification and compliance with federal and state agency reporting requirements. Disclosure of your social security number is voluntary.)

How did you hear about us? ____
Would you like to be listed as a supporter of Naturopathic Medicine for our legislative efforts?
___ Yes ___ No

What is your current living and relationship situation? ____________________________

Emergency contact: ____
(Name) (Phone)
Relationship: ____

What are your most important health concerns in order of importance?
1.
2.
3.
When and where did you last receive healthcare? ________________________________

What was the reason? ____

List any previous hospitalizations or surgeries:_________________________________

List any prescription or over-the-counter medications or natural supplements that you are currently taking:

List any allergies that you have, including environmental, food or medication:

Circle any of the following childhood illnesses that you have had:

Diphtheria   Polio   Measles   Mumps   Rubella   Pertussis   Other___________________

Mother's age or age at death: _________________

Health condition: ____

Father's age or age at death: __________________

Health condition: ____

Circle any health conditions that members of your immediate family may have, such as:
(cancer, diabetes, heart disease, high blood pressure, stroke, epilepsy, mental illness, asthma, hay fever, hives, anemia, kidney disease, liver disease, gallbladder disease, ulcer, tuberculosis, goiter, arthritis, heart murmur, cataracts, glaucoma, etc) & list any not mentioned above:

General

Weight ________ Height ________ Weight 1 year ago _______ Max weight _______ When _________

Habits

What are your main interests and hobbies?

Do you exercise? Y N

What form and how often?

Do you eat three meals each day?	Y N		Awaken rested?	Y N
Average 6-8 hours sleep per day?	Y N		Sleep well?	Y N
Enjoy your work?	Y N		Take vacations?	Y N
Spend time outside?	Y N	Hours/day? ____		
Read	Y N		Have a spiritual practice?	Y N
Watch television	Y N	Hours/day? ____		
Use recreational drugs?	Y N		Been treated for drug dependence?	Y N
Use Alcoholic beverages?	Y N		Been treated for alcoholism?	Y N
Use tobacco?	Y N			

Review of systems

Please circle correct answer for the conditions below:

Y = current condition ***P = past condition***

Skin

Rashes	Y P	Eczema/hives	Y P	Itching	Y P
Acne/boils	Y P	Color changes	Y P	Lumps	Y P
Night sweats	Y P				

Head

Headache	Y P	Head injury	Y P

Eyes

Impaired vision	Y P	Glasses/contacts	Y P	Eye pain	Y P
Tearing/dryness	Y P	Double vision	Y P	Glaucoma	Y P
Cataracts	Y P				

Ears

Impaired hearing	Y P	Ringing	Y P	Earache	Y P
Dizziness	Y P	Frequent infections	Y P	Herpes	Y P

Nose and sinuses

Frequent colds	Y P	Nose bleeds	Y P	Stuffiness	Y P
Hay fever	Y P	Sinus problems	Y P		

Mouth and throat

Frequent colds	Y P	Nose bleeds	Y P	Gum problems	Y P
Hoarseness	Y P	Dental cavities	Y P		

Neck

Lumps	Y P	Swollen glands	Y P
Goiter	Y P	Pain or stiffness	Y P

Respiratory

Cough	Y P	Spitting up blood	Y P	Sputum	Y P
Wheezing	Y P	Asthma	Y P	Bronchitis	Y P
Pneumonia	Y P	Emphysema	Y P	Pleurisy	Y P
Difficult breathing	Y P	Pain on breathing	Y P	Tuberculosis	Y P
		Shortness of breath	Y P		

Cardiovascular

Heart disease	Y P	Angina	Y P	High blood pressure	Y P
Murmurs	Y P	Palpitations	Y P	Rheumatic fever	Y P
Swelling of ankles	Y P	Chest pain	Y P		

Gastrointestinal

Trouble swallowing	Y P	Heartburn	Y P	Change in thirst	Y P
Change in appetite	Y P	Nausea	Y P	Vomiting	Y P
Blood in stool	Y P	Belching/passing gas	Y P	Jaundice (yellow skin)	Y P
Liver disease	Y P	Gall bladder disease	Y P	Ulcer	Y P

Bowel movements: how often?____________Is this a change?

Urinary

Pain on urination	Y P	Increased frequency	Y P	Frequency at night	Y P
Inability to hold urine	Y P	Frequent infections	Y P	Kidney stones	Y P

Female reproductive

Age menses began?	____________	Average # of days?	____________	Length of cycle?	_________
Bleeding between periods	Y P	Irregular cycles	Y P	Pain during intercourse	Y P
Painful menses	Y P	Excessive flow	Y P	Difficulty conceiving	Y P
Number of pregnancies	____________	Menopausal symptoms	Y P	Sexual difficulties	Y P
Number of live births	____________	Sexually transmitted infections	Y P	Are you sexually active?	Y P
Number of miscarriages	____________	Birth control	Y P	Type of birth control	______
Number of abortions	____________	Do you do self breast exams?	Y N	Lumps	Y P
Breast pain or tenderness	Y N	Nipple discharge	Y P		

Sexual orientation: ☐Heterosexual ☐Bisexual ☐Homosexual

Male reproductive

Hernias	Y P	Testicular masses	Y P	Testicular pain	Y P
Are you sexually active?	____________	Sexual difficulties	Y P	Prostate disease	Y P
Discharge	Y P	Sexually transmitted infections	Y P	Lesions or sores	Y P

Sexual orientation: Heterosexual Bisexual Homosexual

Musculoskeletal

Joint pain or stiffness	Y P	Arthritis	Y P	Broken bones	Y P
Muscle pain/cramps	Y P	Osteoporosis	Y P	Osteopenia	Y P

Peripheral vascular

Deep leg pain	Y P	Cold hands/feet	Y P	Varicose veins	Y P
Thrombophlebitis	Y P				

Neurological

Fainting	Y P	Seizure	Y P	Paralysis	Y P
Muscle weakness	Y P	Loss of memory	Y P	Numbness/tingling	Y P

Emotional

Depression	Y P	Anxiety or nervousness	Y P
Mood swings	Y P	Tension	Y P

Endocrine

Hypothyroid	Y P	Hyperthyroid	Y P	Diabetes	Y P
Excessive thirst	Y P	Excessive hunger	Y P	Heat/cold intolerance	Y P

Blood

Anemia	Y P	Easy bleeding or bruising	Y P

Naturopathic Medical Consent: I consent to services rendered and provided to me under the instructions of the staff physicians of the Holistic Family Wellness Clinic.

Financial Agreement: The undersigned, in consideration of services to be rendered to the patient, agrees to pay the provider of service, in accordance with their regular rates and terms, for the services rendered. All payment is due at time of service. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal. All insurance benefits available for professional and clinic services rendered, will be returned to the patient to offset the costs incurred by the patient.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signature: ____ Date: __________________

Parent/guardian signature if patient is a minor: ___________________________________

Thank You!