NATUROPATHIC HEALTH HISTORY – Adult

Name _____ Today's date: _____

Date of Birth _____ Age _____ Gender _____

Place of birth (city/country) _____

PHN _____

Current Address _____ Postal Code _____

Phone (H) _____ (W) _____ (cell/pager) _____

Please circle the best phone number for leaving messages.

E-mail address _____

Occupation/Place of work _____ full/part-time? _____

How did you hear about me? _____

EMERGENCY CONTACTS

Name _____ Phone (H) _____ (W) _____

Address _____ Relationship _____

Name _____ Phone (H) _____ (W) _____

Address _____ Relationship _____

OTHER HEALTH CARE PROVIDERS (medical doctors, chiropractors, therapists, etc.)

1. _____ Ph: _____
2. _____ Ph: _____
3. _____ Ph: _____
4. _____ Ph: _____

What is your main health concern (your main reason for seeking naturopathic care)?

What are your other main health concerns, in order of importance to you:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Have you received medical attention, or any other form of health care, for your main health concerns? If so, please indicate what and if any of the treatments you've received have been successful.

Are you still receiving this care? Y N

Please list all current medications (prescription or over-the-counter), supplements, herbal remedies, homeopathic remedies, etc. that you are taking:

_____
_____
_____
_____
_____

Please list all past medications, supplements, etc. that you are no longer taking, and indicate results and/or adverse effects:

_____
_____
_____
_____
_____

Have you had any recent laboratory tests (i.e. blood drawn, x-rays, others)? Please list below:

Do you get regular screening tests with your medical doctor? (PAP's, mammogram, PSA, Cholesterol, etc.) If yes, please indicate what, and dates of the last tests.

_____

MEDICAL HISTORY

How would you describe your general state of health? _____
Height _____ Weight _____ Weight 1 year ago _____

Minimum adult weight _____ Maximum adult weight _____ (not including pregnancy)

On average, how would you describe your energy level (scale of 1-10, with 10 the highest) _____

Stress can have a large impact on our health. Please list below any significant stressors in your life, past or present. Indicate dates or time frames of these stressors.

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Do you currently work with a professional counselor, psychologist, social worker, priest, rabbi, psychiatrist, or other therapist? Y N Have you in the past? Y N

Please list all known allergies:

Foods: _____
Animals: _____

Medications: _____

Environmental/Seasonal: _____

Please indicate any previous injuries, serious illnesses, or hospitalizations. Include dates (approximate) if possible:

How many times have you been treated with antibiotics? _____

Most recent antibiotic use, and what for _____

Do you regularly use any of the following? (if yes, please indicate frequency)

Painkillers _____ Laxatives _____ Antacids _____

Diet pills _____ Birth control pills, implants, i.u.d., _____

Alcohol _____ Tobacco _____ Past smoker? **Y N**

Caffeine (tea, coffee, coke) _____

Antihistamines _____

Recreational drugs (which ones) _____

Have you had any of the following immunizations, either as a child or as an adult?

___ DPT (Diphtheria, Pertussis, Tetanus)

___ Tetanus booster; most recent? _____

___ MMR (Measles, Mumps, Rubella)

___ Haemophilus influenza B (HiB)

___ Flu shot

___ Polio

___ Hepatitis A

___ Hepatitis B

___ Other _____

Did you have any adverse reactions to any of the above? (i.e. seizures, rashes, fever, etc.)

_____

I don't know my immunization history ____

Have you recently traveled to tropical areas? _____

Which of the following childhood conditions have you had?

Rubella (German measles)	Measles	Mumps
Chicken pox	Polio	Scarlet Fever
Pneumonia	Bronchitis	Roseola
Colic	Ear infections	Whooping cough
Asthma	Eczema	Hay fever
Impetigo	Tonsillitis	Strep throat
Mononucleosis	Rheumatic fever	Other _____

Which of the following have you had as an adult?

Chronic infections	High blood pressure	Low blood pressure
Pneumonia	Bronchitis	Psoriasis
Anemia	Hypoglycemia	Diabetes, 1 or 2
Heart disease	Stroke	High cholesterol
Hepatitis	Cancer	Kidney infections/disease
Asthma	Eczema	Hay fever
Arthritis/chronic joint pain	Depression	Anxiety
Mental Illness	Mononucleosis	Thyroid problems
Seizures	STD's	Cold sores
Canker sores	Weight problems	Alcoholism
Drug Addictions	HIV	Other _____

FAMILY MEDICAL HISTORY

Do any of the <u>above conditions</u> appear in your family history? Please indicate in the space below:

___ I don't know my family medical history.

Please list approximate age, main health concern (if known), and, if deceased, cause of death, for the following members of your family (to the best of your knowledge).

	Age (if living)	Main health concern	Age at death	Cause
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
<u>Maternal:</u>				
Grandmother	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____
<u>Paternal:</u>				
Grandmother	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____

Do you have any children? Y N If yes, how many? _____

Do they have any health problems? _____

Have you ever in the past, or currently, been diagnosed with a mental illness? Y N
If yes, please indicate what _____

What would you say is your strongest area of health? _____

What would you say needs the most attention? _____

DIETARY HISTORY

Do you have any dietary restrictions, religious or ethical?

_____

Food cravings / Favourite foods: _____

Food aversions: _____

Have you ever noticed any questionable reactions to foods that have not been diagnosed as allergies?

_____

LIFESTYLE

What do you enjoy most in your life? _____
What are your interests/hobbies? _____

Are you (please circle):
Married In relationship/dating Single Separated/Divored Widowed

Do you exercise regularly? Y N
What do you do for exercise, how often, and at what intensity?

_____

Do you enjoy your chosen form of exercise? **Y** **N**

LIFE, HOME & WORK

What do you worry about most in your life? _____

Do you have a religious or spiritual practice? _____
What is your occupation (employed, student, stay-at-home parent, etc.)? _____
Is this fulfilling for you? **Y** **N**
Do you take vacations? **Y** **N**

How many hours per week do you work? (Employed or otherwise)

How many hours do you sleep most nights?

How many hours per day do you spend on the computer or in front of a television?

How many hours per day do you spend in your car?

Are you regularly exposed to tobacco smoke? **Y** **N**
Are there animals at home or at work? **Y** **N**

How is your home heated? _____ Is your home damp?_____

Does your home or work expose you to known toxins or hazards? _____

Do any of your hobbies/interests expose you to toxins or hazards? _____

What are your current living arrangements? _____
How would you describe the emotional climate in your home? _____
How stressful is work/home life? _____
How much do you perceive this to impact on your health? _____
What do you do to deal with stress? _____

WOMEN:

Age of first period _____ Age at menopause _____ Length of each period _____

Length of cycles _____ Regular/irregular? (circle one) Bleeding between periods? **Y** **N**

Please describe a typical period, in terms of flow, colour (dark or light), clotting, etc.

_____

Do you experience any of the following associated with PMS? (please circle)

Bloating Cramps Breast tenderness Irritability Depression Moodswings Headaches Bowel changes
Clumsiness Lethargy/Fatigue Change in appetite Brain fog Acne
Other: _____

Are you sexually active? **Y** **N** If you use birth control, which kind? _____

Number of pregnancies _____ Number of live births _____ Abortions/Miscarriages _____
Difficulty conceiving? _____

Date and result of last PAP smear _____

Date and result of last mammogram _____
Do you do self breast exams? **Y** **N**

Have you experienced menopause? _____What age? _____ Difficulties? _____
Please briefly describe any symptoms you are experiencing, associated with menopause:

_____

MEN:

Any difficulties with urinating? (please describe) _____
How often do you get up at night to urinate? _____ Since when? _____
Any difficulties with impotency (getting or maintaining an erection)? **Y** **N**

Any prostate problems that you know of? _____
Date and result of last prostate exam _____

Any STD's (Sexually Transmitted Diseases) that you know of? _____

Are you sexually active? **Y** **N** If you use birth control, what kind? _____
Do you have children? _____

Have you ever had any difficulty conceiving with a partner? _____

AND FINALLY……..

Please describe, in the space below, your health goals:

Is there anything else that you feel is important that has not been covered by the questions in this form?

Thank you for taking the time to fully complete this form.

Your diligence is appreciated and important to the process of taking good care of your health.

If you have any questions about any item on this form, please contact me at the number below.
All information on this form is confidential and will not be shared with any other individual or company without your explicit and signed consent.

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