

NATURE'S PATH OF INTEGRATED HEALTH

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Date: _____

Patient Profile

Name: _____ Age: _____ Birthdate: _____ Gender: M F

Address: _____

Phone: **hm** _____ Can messages be left for you here? Y N **wk** _____ Can messages be left here? Y N

Occupation: _____ Employer: _____

email: _____

Name of Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Who can I thank for referring you to me? _____

A note to patients: Please take the time to carefully complete this health history questionnaire. Naturopathic medicine involves providing the physician a complete picture of the patient physically, mentally & emotionally. This is a confidential record of your medical history and will not be released except when you have authorized me to do so. Thank you.

Present Health Concerns: Please list your most important health concerns in their order of significance.

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

What goals do you have for your visit at the clinic today?

Primary Goal: _____

Other Goals: _____

Have you ever consulted a naturopathic doctor before? Yes No

Do you have any questions about naturopathic medicine or Nature's Path of Integrated Health before we get started? _____

Prior Doctor-Patient Relationship

Please take a moment to reflect on your past relationships with physicians and note how the relationship with future physicians could improve to optimize your health care. What do you need from a physician in relation to achieving your goals and goals of wellness (creativity, energy, enjoyment, health, balance, etc)? How can you become more effective in your role with your physician?

PLEASE TURN OVER →

Please list the medications that you are currently taking, with dosages:

- 1.) _____ 4.) _____
- 2.) _____ 5.) _____
- 3.) _____ 6.) _____

Please list any vitamins, minerals, herbs or homeopathic remedies that you are presently taking:

- 1.) _____ 5.) _____
- 2.) _____ 6.) _____
- 3.) _____ 7.) _____
- 4.) _____ 8.) _____

Please list any allergies that you have to any of the following:

Drugs: _____ Foods: _____

Environmental Sources: (ex. Pollen, grasses, etc...) _____

What happens when you have an allergy attack? _____

Personal Habits:

Tobacco: _____ packs per day; smokeless tobacco, cigars

Coffee/black tea/ cola _____ cups per day/week/month

Alcohol _____ drinks per day/week/month

Recreational drugs _____

Do you follow any particular diet regimens or restrictions? YES NO

If yes, please describe: _____

Do you exercise regularly? YES NO If yes, please describe: _____

Do you make time for rest, relaxation, or meditation during the day and/or before bed? YES NO

Have you ever been expose to toxic chemical, solvents or other possible toxins? YES NO

If yes, please describe: _____

Past History:

Hospitalizations: (Please list reason and dates)

Serious Illnesses and Injuries:

Date of last complete physical exam: _____

Social History:

Please circle those that apply: single married significant other

Do you have children? YES NO How many? _____ Ages: _____

Does income meet monthly expenses? YES NO

Have you traveled outside the US in the past year? YES NO Where? _____

Please describe briefly your religious and/or spiritual background/beliefs _____

Family History: Please fill in the boxes below for each condition that applies to one of you family members.

	YES	WHO	Comments		YES	WHO	Comments
Alcoholism				Hay Fever, Hives			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other:			

PATIENT PROFILE

REVIEW OF SYSTEMS: Y = a condition you have now. N = never had P = have had in the past
For the following, PLEASE CIRCLE, or fill in blanks.

GENERAL

Weight _____
 Weight 1 year ago _____
 Maximum weight _____
 When _____
 Height _____
 Night Sweats Y P N
 Fatigue Y P N

SKIN

Rashes Y P N
 Inflammation Y P N
 Infection Y P N
 Growths Y P N
 Changes in hair/nails Y P N

HEAD

Headache Y P N
 Head Injury Y P N

EYES

Impaired vision Y P N
 Eye pain Y P N
 Tearing or dryness Y P N
 Double vision Y P N

EARS

Impaired hearing Y P N
 Ringing Y P N
 Ear ache/itch Y P N
 Dizziness Y P N

NOSE & SINUSES

Frequent colds Y P N
 Nose bleeds Y P N
 Stuffiness Y P N
 Sinus problems Y P N
 Post nasal drip Y P N

MOUTH & THROAT

Frequent sore throat Y P N
 Sore tongue Y P N
 Sores in mouth /on lips Y P N
 Gum problems Y P N
 Hoarseness Y P N
 Dental Problems Y P N

NECK

Swollen glands Y P N
 Pain or stiffness Y P N

BLOOD

Anemia Y P N
 Easy bleeding or bruising Y P N

RESPIRATORY

Cough Y P N
 Spitting up blood Y P N
 Wheezing Y P N
 Difficulty breathing Y P N
 Pain on breathing Y P N
 Shortness of breath Y P N
 “ lying down Y P N
 “ at night Y P N
 Positive TB test ever? Y P N

HEART

Heart disease Y P N
 High blood pressure Y P N
 Rheumatic fever Y P N
 Chest pain Y P N
 Swelling in ankles Y P N
 Palpitations, fluttering Y P N

DIGESTION

Trouble swallowing Y P N
 Heartburn Y P N
 Stomach pain Y P N
 Change in thirst Y P N
 Change in appetite Y P N
 Nausea Y P N
 Vomiting Y P N
 Bowels move: daily more less
 Loose stools Y P N
 Is this a change? Y P N
 Blood in stools Y P N
 Belching or gas Y P N
 Liver/gall bladder disease Y P N
 Hemorrhoids Y P N

CIRCULATION

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

MALE REPRODUCTION

Hernias Y P N
 Testicular masses Y P N
 Testicular pain Y P N
 Discharge or sores Y P N
 Difficulty stopping or starting urination Y P N
 Ever any prostate problems Y P N
 Date of last prostate exam _____

FEMALE REPRODUCTION

Age menses began _____
 No. of days menstrual flow _____
 Length of complete cycle _____
 DATE of last menstrual period _____
 Bleeding between periods Y P N
 Are cycles regular Y P N
 Cramps Y P N
 Abnormal vaginal discharge Y P N
 Excessive flow Y P N
 PMS Y P N

DATE of LAST PAP Smear _____
 Results were: normal abnormal don't know
 EVER had an abnormal PAP? Y P N
 No. of pregnancies _____
 No. of live births _____
 No. of miscarriages _____
 No. of abortions _____
 Menopausal symptoms Y P N

GENERAL REPRODUCTION (males and females)

Birth control? Y P N
 What type? _____
 (F)Ever used birth control pills? Y P N
 If so, how long? _____
 Difficulty conceiving Y P N
 Are you sexually active? Y P N
 Sexual difficulties Y P N
 Pain during intercourse Y P N
 Venereal disease Y P N

(The following question is optional)

Sexual orientation:
 Heterosexual __ Homosexual __ Bisexual__

BREASTS

Do you self exam regularly Y P N
 Lumps Y P N
 Pain or tenderness Y P N
 Nipple Discharge Y P N

MENTAL / EMOTIONAL

Depression Y P N
 Mood Swings Y P N
 Anxiety or nervousness Y P N
 Tension Y P N
 Suicide thoughts Y P N
 Suicide attempts Y P N

ENDOCRINE

Ever had any thyroid problem Y P N
 Heat or cold intolerance Y P N
 Hypoglycemia Y P N
 Excessive thirst Y P N
 Excessive hunger Y P N
 Easy weight gain Y P N

NEUROLOGIC

Fainting Y P N
 Seizures Y P N
 Paralysis Y P N
 Muscle weakness Y P N
 Numbness or tingling Y P N
 Loss of memory Y P N

URINARY

Pain on urination Y P N
 Increase frequency Y P N
 Frequency at night Y P N
 Inability to hold urine Y P N
 Bladder infections Y P N

MUSCULOSKELETAL

Joint pain or stiffness Y P N
 Broken bones Y P N
 Muscle spasms or cramps Y P N
 Weakness Y P N

INDICATE on diagram any PROBLEM AREAS:

IS THERE ANY OTHER PROBLEM YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR? _____