Health History Summary

Date ________________

Name ___________________________________ Age _____ Birthdate ____________ Occupation ____________________

Mailing Address ____________________________________ City ______________________ State ____ Zip ____________

Phone (day) ____ (evening) ____

Contact in case of emergency ____

Phone ____ Relationship to you _________________________________

Physicians or health practitioners seen in past year ____

____

For what condition(s)? ____

Your Current Health Concerns

What is your **main** reason for seeking naturopathic care? If you have a specific health condition, please describe it, including the first time you noticed your condition and the factors you suspect play a role in its onset and continuation.

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In *order of importance,* current health concerns:

<u>Condition/concern</u> <u>Length of time</u>

1) ____

2) ____

3) ____

4) ____

Other concerns: ____

____

Is your main problem *getting better, getting worse or staying the same*? (circle one)

Treatments you have received for your main problem: ____

____

Have you ever sought care from a naturopathic physician, chiropractor, acupuncturist or other complementary practitioner? ____

Was the therapy helpful? Y / N

Your Health History

General state of health (circle one): excellent good average fair poor

Overall energy level from 1-10 (10 is highest and 1 is lowest) ________________

Time of day your energy level the best: _________________ Worst: _______________________

Current body weight ___________ Are you happy with your weight now? (Y/N) Weight 1 year ago _________

Height ___________

List the five most significant stressful events in your life, from the most recent to the most distant. Place a star (*) next to any of the situations that you feel continue to impact your life today.

1) ____

2) ____

3) ____

4) ____

5) ____

Have you worked with a professional counselor, psychologist, social worker, pastor or other therapist? ________________

What do you do to relieve stress? ____

Are you currently working with a medical doctor or osteopathic physician? __________________

What childhood illnesses have you had?

- ☐ measles
- ☐ mumps
- ☐ chicken pox
- ☐ whooping cough
- ☐ polio
- ☐ diptheria
- ☐ rheumatic fever
- ☐ scarlet fever
- ☐ smallpox
- ☐ typhoid fever
- ☐ tuberculosis

Previous surgeries and hospitalizations (include dates):____

____

Which of the following have you had? Indicate "N" for now if you currently have the condition, "P" if you had it in the past.

____ pneumonia
____ diabetes
____ gonorrhea
____ tonsillitis
____ asthma
____ syphilis
____ ear infections
____ eczema
____ venereal disease
____ chronic infections
____ heart disease
____ epilepsy
____ canker sores
____ herpes
____ high blood pressure
____ allergies
____ hepatitis
____ mononucleosis
____ thyroid problems
____ weight problem
____ anemia
____ other problems ____

Any known allergies to drugs, foods, animals or other: ____

____

Which of the following do you currently use? *Indicate amount, how often and for how long.*

alcohol ________________________________

tobacco ________________________________

hormones ________________________________

coffee ________________________________

cortisone ________________________________

laxatives ________________________________

sedatives ________________________________

antacids ________________________________

Other ***medications, herbs and vitamins***: Give name, dosage and length of time you've been taking each product/medicine.

Name	Dosage	Time Taken	Name	Dosage	Time Taken

Family History

	Living (age)	Health Problems	Died (age)	Cause of Death
Mother				
Father				
Brothers				
Sisters				
Mother's Mom				
Mother's Dad				
Father's Mom				
Father's Dad				

Do you have any **blood relative** who has had any of the following?

- ☐ allergies
- ☐ diabetes
- ☐ heart attack
- ☐ ulcers
- ☐ seizures
- ☐ arthritis
- ☐ anemia
- ☐ genetic problem
- ☐ cataracts
- ☐ sickle cell anemia
- ☐ asthma
- ☐ depression
- ☐ high blood pressure
- ☐ thyroid problems
- ☐ venereal disease
- ☐ cancer
- ☐ skin disease
- ☐ stroke
- ☐ hypoglycemia

What is your ethnicity? ____________ Do you have children? (Y/N) How many & what ages? ____________

Do any of your children have any health problems? ____________

You currently live with: ☐ spouse ☐ partner ☐ parents ☐ friends ☐ children ☐ alone

Are you: ☐ married ☐ separated ☐ divorced ☐ widowed ☐ single ☐ in a supportive relationship

Current level of education: ____________ Are you satisfied with this? Y/ N

Personal Habits

What do you enjoy most in your life? ____________

What do you worry most about in life? ____________

Do you exercise? Y/ N If yes, what kind and how often? ____________

Rate the quality of your sleep on a scale of 1-10 (10 being great): ____________

Time you retire in the evenings: ____________ Time you wake up in the morning: ____________

Do you wake during the night? Y/ N How often? ____________

Do you wake up feeling refreshed? Y/ N Do you have night sweats? Y/ N

Do you nap during the day? Y/ N For how long? ____________

Compared to others' temperature, are you usually *warmer, cooler or average?* (Circle One)

General temperature of your hands and feet: *warm, cool or average.* (Circle One)

Do you enjoy your work? Y/ N Do you take vacations? Y/ N How often? ____________

How often do you get colds, flus, sore throat and/or yeast infections in a 1 year period? ____________

When you rise quickly from a sitting or lying position, do you ever get dizzy? Y/ N If yes, how often? ____________

Digestion (*circle* or fill in answer)

Do you have any problems with *gas, bloating or fullness* after eating? Y/ N How often? ____________

How often do you have bowel movements? ____________ Any rectal itching? (Y/N)

Do you ever have any *blood, mucus, undigested food, black stools* ? Do your stools tend to be formed or loose? (circle one)

How often do you have diarrhea? ____________ Do you ever have alternating constipation and diarrhea? (Y/N)

Have you ever fasted? (Y/N) For how long? ____________

How did you feel while you were fasting? ____________

Travel outside the U.S. in the last 5 years? (Y/N) Where? ____________ Camping in the last 5 years? (Y/N)

Reproductive System

WOMEN

Age of first menses_____________________ If periods have stopped, at what age did they stop? ________________________

Are cycles regular? (Y/N) Period begins every ______________________ days and last __________________days.

On your heaviest day of menstrual flow, how many pads or tampons do you use in a 12 hour time span? _______________

Do you have any spotting or bleeding between periods? (Y/N) Any cramps with period? (Y/N)

List premenstrual symptoms if any: ____

Number of: pregnancies _________ abortions_________ live births ____________miscarriages ___________

Any problems getting pregnant? (Y/N)

MEN

How often do you get up at night to urinate? _____________ Is this an increase in the past few years?___________________

Do you have any problems with impotency (getting or maintaining an erection)? (Y/N)

Any sores on penis? (Y/N) Any prostate problems? (Y/N)

Have you ever had your prostate examined? (Y/N) When? ____

WOMEN & MEN

Are you currently sexually active? (Y/N) Are you hetero / homo / bi sexual? (circle one)

How often do you have intercourse? ____________________ Is this more or less than 1 year ago?_______________________

Method of birth control: _______________________________ Past methods: ____

Have you ever been physically or sexually abused? (Y/N)

Are you currently breastfeeding? (Y/N) Have you ever? (Y/N) For how long?___________________________________

Do you have concerns about HIV/AIDS or any other sexually transmitted diseases? (Y/N)

Please list any other concerns about sexual and/or reproductive health: ____________________________________

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Kidneys and bladder

How many bladder infections have you had in the last 3 years?________ How were they treated? _____________________

Burning sensation during or after urination? (Y/N) Does urine have strong odor (Y/N)

Color of urine: dark yellow bright yellow cloudy pale clear (circle one)

Difficulty starting or stopping when urinating (Y/N) Difficulty perspiring (Y/N) Perspire with exercise (Y/N)

Lifestyle

Time at present address?_____________

Where did you live previously?____

Describe you home's environment: (Examples are old home, new home, moldy, dry, damp, etc.)________________________

____

Specialized air filtration in home? (Y/N) Toxic fumes or chemicals in work or home environment? (Y/N)

Any hobbies that involve toxic materials? (Y/N) Do you smoke? (Y/N) Exposed to second hand smoke? (Y/N)

Type of drinking water? (bottled, filtered or tap)____

Do you have anything else you feel is important for me to know to assist you in your health?__________________________

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