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.

_____

_____

_____

_____

In *order of importance,* current health concerns:

Condition/concern Length of time

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

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: _____

_____

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?_____

_____

_____

_____

_____