Note: The information you provide is confidential and will be secured via HIPAA regulations. Please complete this questionnaire as thoroughly as possible. Thank you.

Name: _____ Age____ Birth Date_____ Sex: __M __F

Address (St, Town, State, Zip): _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email address: _____ I would like the free newsletter __ Y __N
Permission to contact you (reminder calls, laboratory results, supplement pick up, etc.): __Y __N
Preferred method of contact: __Email __Cell Phone __ Home phone __ Other: _____

Social Security # (optional): _____

Medical Insurance Company & Plan: _____

Card #: _____ Group#: _____

Emergency contact: _____ Phone number: _____

Allergies (medications, foods, etc.): _____
Primary care physician (name, location, phone number):

_____

Have you seen a Naturopathic Doctor before? _ Y _ N Name: Dr._____

Have you seen an Acupuncturist before? _ Y _ N Name: _____

Have you seen a Nutritionist before? _ Y _ N Name: _____

Why did you choose our clinic (or referred by)?

_____

Primary Health Concerns: Please list your top 3 primary health concerns in order of importance.

Concern	Onset Date	Severity
ex: Headache	*ex. June 1992*	*Mild/Moderate/Severe*

1._____

2._____

3._____

What are your top 2 therapeutic goals for your course of treatment with us?
1._____

2._____

Please list hospitalizations, surgery, or serious injuries with the date and type illness/operation/injury:
_____

_____

Patient Name: _____ Birth Date: _____

Please circle or fill in where indicated if you have ever had any of the following conditions:

Acne
Alcohol or drug abuse
Allergies_____
Anemia
Anxiety
Arthritis _____
Asthma /Lung disease
Back pain
Bladder/Urinary problems
Bipolar Disorder
Cancer_____
Chest pain/ Palpitations
Chickenpox
Colitis/irritable bowel
Depression
Diabetes _ Type I _ Type II
Ear or hearing problems
Eating Disorders_____
Edema/water weight
Epilepsy/ Seizures
Eye problems/Cataracts/ Glaucoma
Fatigue, chronic
Fibromyalgia
Female/PMS/gyn problems
Frequent colds/antibiotic use
Gall bladder/ Liver problems
Gastrointestinal problems
_____
Gum/teeth problems
Hair loss
Hay fever
Headache/ Migraine
Heart problems_____
Hemorrhoids
Hepatitis _ A _ B _ C _ Other
High Blood Pressure
High Cholesterol
HIV/AIDS
Hypoglycemia
Impotence/Sexual issues
Kidney/ Urinary problems
Measles/ Mumps/ Rubella
Mental illness _____
Mononucleosis / Epstein Barr virus/ Cytomegalovirus
Panic Attacks
Parasites_____
Prostate problems
PTSD
Reflux/GERD
Rheumatic fever
Sexual abuse
Sexually transmitted diseases (herpes, chlamydia, gonorrhea, etc.)_____
Sinusitis
Skin problems/rashes
_____
Stroke
Suicidal thoughts/ actions
Thyroid problems
Tuberculosis
Ulcers _____
Weight Gain/Obesity
Other
_____
_____
_____

Please list current nutritional supplements, herbs, homeopathics, topicals, OTC and prescription medications:

Supplement/over-the-counter	Date Started	Dosage	Frequency of Use
Ex. Vitamin C	Ex. 4/8/2016	Ex. 500 mg	Ex. Once daily

Medications	Date Started	Dosage	Frequency of Use
Ex. Alavert (loratadine)	Ex. 6/12/2016	Ex. 10 mg	Ex. Once daily

Patient Name: _____ Birth Date: _____
What is your present level of commitment to your health? Rate from 10% to 100%: _____
What is your primary requirement for a successful therapeutic relationship with a physician or nutritionist?
_____

What behaviors or lifestyle habits do you engage in regularly to support your health? (please list)
_____

_____

If necessary to reach my health goals, I am able and willing to:
___Take supplements ___Exercise ___Optimize my diet ___Optimize my sleep
___Change my daily lifestyle habits ___Take herbal medicines ___Address psycho-emotional issues
___Do stress management/ relaxation techniques

Work and Social History:
Occupation: _____ Hours work/week: _____ Do you enjoy your work? __Y __N__NA

Are you currently in a relationship? __ Y __ N Do you enjoy your current relationship status? __ Y __ N__NA

Type of relationship (married, divorced, etc): _____

Caring for: Children (ages): _____ Elderly relatives (condition): _____

Active spiritual practice? _Y _N Orientation (ex. Christian, Jewish, Buddhist, Muslim, etc.)
_____

Height _____ Current Weight: _____ lbs Weight 1 year ago: _____ lbs Max. weight: _____ lbs

Smoker _ Y _ N If yes, smoked for _____ years Amount per day_____ Year stopped _____

Alcohol _ Y _ N If yes, type_____ Frequency_____ Abuse history? _____

Recreational Drugs _ Y _ N If yes, type_____ Frequency_____ Abuse history? _____

Exercise _ Y _ N If yes, describe type and frequency _____

_____

What are the major stressors in your life? _____

_____

How do you usually deal with stress? _____

Sleep: Average hours of sleep per night? _____ History of sleep problems? _ Y _ N Snoring? _ Y _ N

Diet: Are you happy with your current diet? _____ If not, what would you like to change?

_____

Patient Name: _____ **Birth Date:** _____

Please briefly describe the usual items you would have for each meal:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks (coffee, tea, cola, water, etc.): _____

Food Restrictions / Sensitivities: _____

_____

Date of last physical exam: _____ **Date of last laboratory/blood work and significant results:**

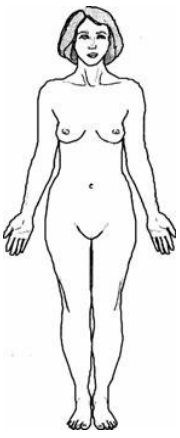
_____

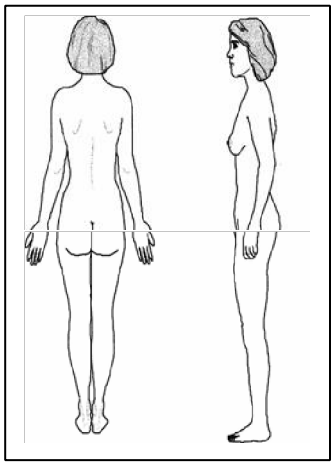
Date of last pap smear/prostate exam: _____**Date of last mammogram:** _____

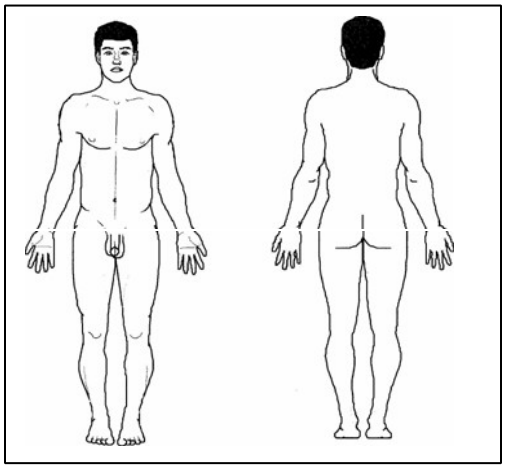
Your birth and childhood history (prolonged labor, forceps, breast/formula fed, chronic infections, antibiotic history, etc.): _____

Significant traumas (auto accidents, brain injuries, concussions, sexual/verbal abuse, etc.): _____

_____







Please circle any current areas of pain on the ABOVE diagrams.

Patient Name: _____ **Birth Date:** _____

Family Medical History:
Please place a check in the appropriate column for relevant diseases according to each family member:
Note: For Children, please note "S" for Son and "D" for daughter. For grandparents please use "MGM" or "MGF" (maternal grandmother or grandfather) and "PGF" or "PGM" (paternal grandfather or grandmother)

	Father	Mother	Brother(s)	Sister(s)	Children	Grandparents
Age if living:						
Age of death:						
Cause of death						
Cancer						
Diabetes						
Depression						
Heart Disease						
High Blood Pressure						
High Cholesterol						
S troke						
Epilepsy/ Seizures						
Mental Illness						
Asthma						
Kidney Disease						
Inherited Blood Disorder						
Tuberculosis						
Thyroid/Endocrine Disease						
Multiple Sclerosis						
Neurological Disease						
Autoimmune Disease						
Alcoholism						
Arthritis						
Other (please list):						

Patient Name: _____ Birth Date: _____

Diet/Nutrition

1) __ Yes __ No **Do you eat five or more "fast food" meals per week?**
2) __ Yes __ No **Do you eat *less* than two portions of fruits and vegetables per day?**
3) __ Yes __ No **Do you react adversely to any food?**
4) __ Yes __ No **Do you address weight management by dieting?**
5) __ Yes __ No **Are you on any special diet (vegetarian, dairy-free, etc.)?**
   Explain:_____
6) __ Yes __ No **Do you have difficulties (e.g. weakness, nausea, etc) you miss a meal?**
   Explain:_____
7) __ Yes __ No **Do you use artificial sweeteners (e.g. NutraSweet, Sweet&Low)?**

Genetics

1) __ Yes __ No **Were there medical problems at your birth?**
2) __ Yes __ No **Do you have any genetic diseases that you know of?** _____

Environment

1) **Do you react adversely when you consume caffeinated beverages? _ Yes _ No**
2) **In your work or home environment, are you exposed to chemicals, cigarette smoke, pesticides, or radiation? _ Yes _ No**
3) **Do you have a history of alcoholism? _ Yes _ No**

Psycho-Social

1) __ Yes __ No **Do you feel less happy than you did a year ago ?**
2) __ Yes __ No **Do you feel your life has little meaning and/or purpose?**
3) __ Yes __ No **Do you believe stress is presently reducing the quality of your life?**
4) __ Yes __ No **Is your sex life less than satisfactory?** ___N/A
5) __ Yes __ No **Have you ever been hospitalized for mental or emotional illness?**
6) __ Yes __ No **Is your primary relationship less fulfilling than it was a year ago?** ___N/A
7) __ Yes __ No **Have you experienced major losses that are negative impacting you?**
8) __ Yes __ No **Do you feel you still have significant issues from your childhood?**
9) __ Yes __ No **Was there a history of alcohol or drug abuse in your family?**

Exercise/Aerobic Conditioning

1) __ Yes __ No **Are your symptoms better with exercise?**

Women Only

1) __ Yes __ No **Do you experience regular problems with PMS (bloat, breast tenderness, moody, cramps)?**
2) __ Yes __ No **Do you regularly have problems with menstrual cramps?**
3) __ Yes __ No **Do you experience irregular menstrual cycles?**
4) __ Yes __ No **Do you experience heavy menstrual periods?**
5) __ Yes __ No **Have you entered menopause?**

 # Pregnancies: _____ # Births: _____ # Premature/ Miscarry: _____
#Stillborn/ Abortion: _____ Age at first menses:_____ Last Pap: _____
Date of last menses: _____ Duration of menses:_____ Days between menses:_____

Men Only

1) __ Yes __ No **Are you currently using anabolic steroids or growth hormone?**
2) __ Yes __ No **Do you have trouble with urination?**
3) __ Yes __ No **Any pain in the area of your prostate gland?**

Last prostate exam_____

Patient Name: _____ **Birth Date:** _____

Review of Systems: *Please CIRCLE or CHECK any of the following that you are experiencing now or have experienced in the past 3 months.*

Energy
_ Decreased libido
_ Dizziness/ Vertigo
_ Fainting
_ Fatigue (Physical)
_ Fatigue (Mental)
_ Poor memory
_ Difficulty focusing
_ Decreased motivation
_ Tend to be warm
_ Tend to be cold
_ Abnormal sweating
_ Other _____

Sleep
_ Difficulty falling asleep
_ Difficulty staying asleep
_ Wakes in early AM and can't go back to sleep
_ Wakes to use bathroom
_ Disturbed sleep
_ Need naps
_ Night sweats
_ Nightmares
_ Other _____

Head
_ Headache/ Migraines
_ Facial Pain
_ Ringing in the ears
_ Poor hearing
_ Earaches
_ Teeth grinding
_ Teeth problems
_ Gum problem
_ Sores on mouth/lips
_ Poor vision
_ Blurred vision
_ Spots floating in eyes
_ Light bothers eyes
_ Dry eyes
_ Nose bleeds
_ Nasal congestion
_ Recurrent sore throat
Other _____

Respiratory
_ Asthma
_ Daily cough
_ Coughing with blood
_ Difficulty breathing
_ Excess sputum/mucus
_ Shortness of breath
_ Frequent colds/ flu
_ Other _____

Cardiovascular
_ High blood pressure
_ Low blood pressure
_ Irregular heartbeat
_ Palpitations
_ Chest pain/ pressure
_ Varicose veins
_ Swelling in hands/ feet
_ Other _____

Psychology
_ Irritability
_ Depression
_ Anxiety
_ Mood swings
_ Increased stress
_ Recent loss
_ Anger issues
_ Eating disorders _____
_ Fear
_ Ongoing worry
_ Hyperactivity
_ Mania/hypomania
_ Suicidal thinking
_ Other _____

Gastrointestinal
_ Nausea
_ Bad breathe
_ Vomiting
_ Poor appetite
_ Food cravings
_ Indigestion
_ Thirsty for hot/cold drinks
_ Abdominal pain
_ Flatulence /burping
_ Bloating /gas pains
_ Loose stools/ Diarrhea
_ Constipation
_ Blood or mucus in stool
_ Black stool
_ Foul smelling stool
_ Rectal pain
_ Other_____

Dermatology
_ Acne
_ Rashes/ Hives
_ Eczema
_ Psoriasis
_ Rosacea
_ Itchy skin
_ Dry skin
_ Other _____

Genito-Urinary
_ Pain/ Burning with urination
_ Urgency to urinate
_ Frequent urination
_ Difficulty urinating
_ Urinary hesitancy
_ Split urinary stream
_ Incontinence
_ History of STD's
_ Other _____

Men
_ Erectile dysfunction/Impotence
_ Penile sores/ Discharge
_ Curved penis
_ Painful intercourse
_ Other _____

Gynecology
_ Vaginal discharge
_ PMS (irritable, moody, bloating, breast tenderness prior to menses)
_ Breast soreness
_ Breast lumps
_ Vaginal sores
_ Vaginal dryness
_ Painful intercourse
_ Infertility
_ Other _____

Musculoskeletal
_ Joint pain/ stiffness
_ Muscle weakness
_ Bone problems
_ Pain
Where:_____
_ Better _ Worse with pressure
_ Better _ Worse with heat
_ Better _ Worse with cold
Other _____

Neurological
_ Seizures
_ Spasms
_ Paralysis
_ Numbness/ tingling
_ Loss of consciousness
_ Other _____