Patient Information

This is a confidential questionnaire designed to help determine the best treatment plan for you.

If you have any questions, please ask. Thank you.

General Information

Name: _____ **Preferred Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Email:** _____

I Prefer to be Contacted by (check one)**: □ Phone □ Email □ Text Message (SMS)**

Personal Information

Birth date (MM/DD/YYYY): _____ **Age:** _____

Sex: □ Female □ Male □ Trans___MTF___FTM Height: _____Weight: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Emergency Contact Name: _____ **Relationship:** _____

Phone Number: _____ **Email:** _____

Medical Information

For what health problems are you seeking treatment today?

_____

_____

Please list in order of importance what symptoms are of concern to you.

1. _____

2. _____

3. _____

4. _____

Please list any other health problems you currently have.

_____

_____

What would you like to achieve through your work at the Natural Healing Wellness Center?

_____

_____

Medical History

Please list any accidents, surgeries, or hospitalizations within the past ten years.

_____

_____

Please indicate significant illnesses you or a blood relative (parent, grandparent or sibling) have had:

Illness	*You*	*Relative*	*Date Diagnosed*
Asthma	□	□	_____
Allergies	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Glaucoma	□	□	_____
Hepatitis	□	□	_____
Heart Disease	□	□	_____
High Blood Pressure	□	□	_____
High Cholesterol	□	□	_____
Migraines	□	□	_____
Osteoporosis	□	□	_____
Seizures	□	□	_____
Stroke	□	□	_____
Rheumatic Fever	□	□	_____
Tuberculosis	□	□	_____
Thyroid Disease	□	□	_____

Please indicate if any of the following are true:

□ I have known allergies_____

□ I have a pacemaker

□ I am taking Coumadin / Warfarin

□ I am taking Lithium

Have you ever been diagnosed with a <u>Sexually Transmitted Infection</u>? □ Yes □ No □ Never tested

If yes, please indicate type and date:

□ Chlamydia	□ Past	□ Current	□ HIV	□ Past	□ Current
□ Gonorrhea	□ Past	□ Current	□ Genital warts	□ Past	□ Current
□ Oral herpes	□ Past	□ Current	□ Syphilis	□ Past	□ Current
□ Genital herpes	□ Past	□ Current	□ Other: _____	□ Past	□ Current

Have you ever been diagnosed with a <u>psychological disorder</u>? □ Yes □ No □ Never tested

If yes, please indicate type and date.

□ ADHD _____

□ Anxiety Disorder _____

□ Bipolar Disorder _____

□ Depression _____

□ Eating Disorder _____

□ OCD _____

□ Schizophrenia _____

□ Other: _____

Please list all prescription medications, supplements, herbal supplements, and over the counter

medicines you currently take on a regular basis: (Continue on back if necessary)

Name	*Dosage*	*Reason*	*How long*	*Prescribed by*	*Date of last checkup*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

For Women

Date of last:
Gynecologic exam**:** _____
Mammogram**:** _____
Pap Smear**:** _____
Results?**:** _____
_____

Are you pregnant now? □ Yes □ No □ Unsure
# of pregnancies: _____
# of live births: _____
# of miscarriages: _____
# of abortions: _____

Age of first period (menarche): _____ **Age of menopause (if applicable):** _____
Is your menses regular? □ Yes □ No
Average # of days of flow: _____
The flow is: □ Light □ Normal □ Heavy
The color is: □ Normal □ Dark □ Purple □ Light Brown □ Brown
Clots? □ Yes □ No Color: _____
Average # of pads/day: 1st day: _____ **2nd day:** _____ **3rd day:** _____ **4th day:** _____ **+ days:** _____

Please indicate menstruation related signs/symptoms:

□ Cramps
□ Discharge
□ Swollen or tender breasts
□ Constipation
□ Diarrhea
□ Nausea
□ Headache
□ Hot flashes
□ Night sweats
□ Insomnia
□ Mood swings
□ Increased appetite
□ Decreased appetite
□ Increased libido
□ Decreased libido
□ Pain with intercourse
□ Discharge between periods
□ Bleeding between periods

Location of pain: □ Lower abdomen □ Lower back □ Thighs □ Other: _____
Nature of pain (indicate before, during, or after menses):

□ Aching: _____
□ Bloating: _____
□ Dull: _____
□ Constant: _____
□ Cramping: _____
□ Burning: _____
□ Stabbing: _____
□ Intermittent: _____

For Men

Date of last prostate check up: _____ **PSA results:** _____ **Manual prostate exam results:** _____
Lab results: _____
Frequency of urination: Morning: _____ Afternoon: _____ Evening: _____
Do you get up at night to urinate? □ Yes □ No How often? _____
Check all that apply:

□ Delayed Stream
□ Post urination dribbling
□ Incontinence
□ Retention of urine
□ Decreased force of stream
□ Pain during urination
□ Erectile dysfunction
□ Impotence
□ Difficulty with orgasm
□ Premature ejaculation
□ Decreased libido
□ Increased libido
□ Back pain
□ Groin pain
□ Testicular pain
□ Testicular swelling
□ Other: _____
□ Other: _____

To what extent do these symptoms interfere with your daily activities (work, socializing, sleep, sex, etc.)**?**

_____

Have you sought medical intervention for these problems? □ Yes □ No When? _____

What treatments have you tried for these problems and how successful have they been?

Continue, next page

Social History

How much per day do you use of the following?

Coffee: _____ Cigarettes/Cigars: _____

Tea: _____ Other tobacco products: _____

Soft drinks: _____ Non-medical drugs: _____

Have you ever had a problem with alcohol or alcoholism? □ Yes □ No When? _____

Have you ever had a problem with *dependency* on other drugs? □ Yes □ No

If yes which and when?

_____

Do you have a known history of any exposure to *toxic* substances? □ Yes □ No

If yes, please list which and when you first noticed symptoms.

_____

In the past month, how many days have been seriously affected by your health? _____

How many days did you feel generally poor? _____

How many times were you in the hospital? _____

Please describe your current exercise regimen:

□ Do not exercise □ 3-4 days per week

□ 1-2 days per week □ 5 + days per week

Describe what activities you do: _____

In the past week, how many hours of sleep did you get per night?

□ 4-5 hours □ 8-9 hours

□ 6-7 hours □ 10+ hours

Do you awake feeling rested? □ Yes □ No Do you feel you sleep well at night? □ Yes □ No

Nutritional History

Please list food allergies, food sensitivities, or food cravings that you have.

_____

_____

Do you follow a special diet? □ Yes □ No

If yes, how would you describe the diet? _____

Do you normally eat breakfast? □ Yes □ No

On a normal day, how many meals do you eat?

□ 1 □ 3

□ 2 □ 4 +

During an average week, how many meals do you "eat out"?

□ 0 meals □ 3-4 meals

□ 1-2 meals □ 5+ meals

Please indicate your average water intake.

□ 0 glasses/day □ 3-4 glasses/day

□ 1-2 glasses/day □ 5+ glasses

Health Check List

Please indicate all that apply

Past	Current	Condition
GENERAL		
□	□	Poor appetite
□	□	Excessive appetite
□	□	Change in appetite
□	□	Strong thirst
□	□	Insomnia
□	□	Night sweats
□	□	Sweats easily
□	□	Fatigue
□	□	Fevers
□	□	Chills
□	□	Catch cold easily
□	□	Localized weakness
□	□	Poor coordination
□	□	Bleed or bruise easily
SKIN & HAIR		
□	□	Rashes
□	□	Hives
□	□	Itching
□	□	Eczema
□	□	Acne
□	□	Dryness
□	□	Lumps, Tumors
HEAD & NECK		
□	□	Dizziness
□	□	Fainting
□	□	Headaches
□	□	Migraines
□	□	Concussions
□	□	Other _____
NOSE, THROAT, MOUTH		
□	□	Nose bleeds
□	□	Sinus infections
□	□	Hay fever or allergies
□	□	Recurring sore throats
□	□	Grinding teeth
□	□	Difficulty swallowing

Past	Current	Condition
EARS		
□	□	Infection
□	□	Ringing
□	□	Decreased hearing
□	□	Other _____
EYES		
□	□	Blurred vision
□	□	Visual changes
□	□	Poor night vision
□	□	Spots
□	□	Cataracts
□	□	Eye inflammation
□	□	Glasses/ contacts
□	□	Other: _____
CARDIOVASCULAR		
□	□	High blood pressure
□	□	Low blood pressure
□	□	Blood clots
□	□	Palpitations
□	□	Phlebitis
□	□	Chest pain
□	□	Irregular heart beat
□	□	Cold hands / feet
□	□	Fainting
□	□	Difficulty breathing
□	□	Swelling of hands / feet
□	□	Other: _____
MUSCULAR-SKELETAL		
□	□	Stiff neck/ shoulders
□	□	Back pain
□	□	Muscle spasm/ cramps
□	□	Sore, cold, or weak knees
□	□	Joint pain

Past	Current	Condition
RESPIRATORY		
□	□	Asthma
□	□	Bronchitis
□	□	Frequent colds
□	□	Chronic obstruction
□	□	Pulmonary disease
□	□	Pneumonia
□	□	Cough
□	□	Coughing blood
□	□	Production of phlegm
□	□	Other: _____
GASTRO-INTESTINAL		
□	□	Nausea
□	□	Vomiting
□	□	Diarrhea
□	□	Belching
□	□	Blood in stool
□	□	Bad breath
□	□	Rectal pain
□	□	Hemorrhoids
□	□	Constipation
□	□	Pain or cramps
□	□	Indigestion
□	□	Gall bladder disorder
□	□	Gas
□	□	Other: _____
NEUROLOGICAL		
□	□	Seizures
□	□	Tremors
□	□	Numbness/ tingling limbs
□	□	Concussion
□	□	Pain
□	□	Paralysis
□	□	Other: _____
PSYCHOLOGICAL		
□	□	Depression
□	□	Anxiety/ stress
□	□	Irritability