

# Naturopathic Medical History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ May I add you to my email list?  yes  no

Address: \_\_\_\_\_  
Street City, State, ZIP

Who referred you here? \_\_\_\_\_ Occupation (last 10 years): \_\_\_\_\_

Are you currently receiving other healthcare?  yes  no

If yes, where and from whom? \_\_\_\_\_

## I. Primary Complaint(s)

Please describe the primary problems you are experiencing or the reasons you have requested this appointment. *(Attach additional sheet if needed.)* Please provide a history of each, including:

Complaint:	Started when:	Cause	Severity	What makes it better/worse	Treatments you've tried

What do you intuitively think is causing these imbalances? \_\_\_\_\_

What do you believe needs to be done for you to get better? \_\_\_\_\_

What do you enjoy most in your life? \_\_\_\_\_

Please grade how committed you are to change at this time, in pursuit of achieving health? (mark w/ **X**)

1 (unwilling) \_\_\_\_\_ 10 (completely committed).

Do you have financial constraints which limit your ability to create a treatment plan (this may include lab evaluations, supplements, food and lifestyle changes, exercise equipment, etc.)? (mark w/ **X**)

1 =(constrained, fixed income/no room for adjustments) \_\_\_\_\_ 10 (sufficient financial resources).

### III. Family History

Please check (✓) if any family member(s) have had any of the following:

Condition	Father	Mother	Father's parent	Mother's parent	Sister/Brother	Own Child
Alcoholism						
Allergies						
Arthritis						
Asthma						
Auto-immune disease						
Cancer						
Clotting disorder/Stroke						
Depression or severe anxiety						
Mental Illness						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Osteoporosis						
Thyroid Dysfunction						
Tuberculosis						
Other						
Describe:						

Have you ever had any of the above? (Please add them in Past Medical History).

### V. Female/gynecological history:

**Age of first menses:** \_\_\_\_\_ **Are you in menopause:**  yes  no

**Date of last menses:** \_\_\_\_\_ **Days between periods #:** \_\_\_\_\_

**Days of heavy flow #:** \_\_\_\_\_ moderate \_\_\_\_\_ light \_\_\_\_\_

**Clotting**  yes  no **Cramps:**  Severe  Moderate  Mild  None

**Mid cycle bleeding:**  yes  no

**Pregnancies #:** \_\_\_\_\_ **Abortions/miscarriages #:** \_\_\_\_\_

**Have you had a hysterectomy?**  yes  no

**Are you sexually active?**  yes  no **With** (circle): Men Women Both

**Do you use contraception:**  yes  no **What type?** \_\_\_\_\_

**Abnormal PAP's:**  yes  no

**Are you pregnant now?**  yes  no

**Are you planning on becoming pregnant?**  yes  no

**Do you perform monthly self-check breast exams?**  yes  no

### VI. Male health/history:

**Do you have prostate problems**  yes  no **Explain:** \_\_\_\_\_

**Change in urination pattern:**  yes  no **Explain:** \_\_\_\_\_

**Are you sexually active?**  yes  no **With** (circle): Men Women Both

**Use condoms?** \_\_\_\_\_ **Sexual concern?**  yes  no

**History of sexually transmitted disease:**  yes  no **Explain:** \_\_\_\_\_

**Current medications or supplements and dosages:**

**IV. Review of Systems**

Indicate **(P)** if you've experienced this in your past , (*include age at onset and resolve*) or **(C)** current.

<p><b>General</b></p> <p><b>P C</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent colds</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal disease/STD</p> <p><input type="checkbox"/> <input type="checkbox"/> Bed-wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> <input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight gain (rapid)</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight loss (rapid)</p> <p><input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><b>Head/Eyes/Ears/Nose/Throat</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> Ear noises/ringing</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Ear infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Post nasal drip</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of smell or taste</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye Dryness</p> <p><input type="checkbox"/> <input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen lymph nodes</p> <p><b>Dental</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Canker/cold sores</p> <p>_____ Number of silver filling _____ # removed</p> <p><input type="checkbox"/> <input type="checkbox"/> Root canals</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Gums/Gingivitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Grinding teeth</p> <p><b>Chest/heart/lungs</b></p> <p><input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficult breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Coughs</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive phlegm/mucus</p> <p><input type="checkbox"/> <input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular heart rhythms</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> <input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p>	<p><b>Gastro-intestinal</b></p> <p><b>P C</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Bad Breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Burn</p> <p><input type="checkbox"/> <input type="checkbox"/> Belching</p> <p><input type="checkbox"/> <input type="checkbox"/> Flatus</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervous stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> Bloat</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Stools that float</p> <p><input type="checkbox"/> <input type="checkbox"/> Gallbladder problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Stool color not brown</p> <p><input type="checkbox"/> <input type="checkbox"/> Unformed stools</p> <p><input type="checkbox"/> <input type="checkbox"/> Undigested food in stool</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> Rectal itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in stools</p> <p><b>Kidney/bladder</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Bladder infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney infection or stones</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequency/urgency/discomfort</p> <p><input type="checkbox"/> <input type="checkbox"/> Waking to urinate</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive thirst</p> <p><b>Skin/Hair/Nails</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> <input type="checkbox"/> Acne</p> <p><input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancers/growths</p> <p><input type="checkbox"/> <input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> <input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of hair</p> <p><input type="checkbox"/> <input type="checkbox"/> Thinning eyebrows</p> <p><input type="checkbox"/> <input type="checkbox"/> Herpes type II/genital</p> <p><input type="checkbox"/> <input type="checkbox"/> Yeast skin/nails</p>
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<p><b>Musculo-skeletal/ extremities</b></p> <p><b>P C</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Cold hands/feet</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck pain or stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> <input type="checkbox"/> Swelling of the ankles</p> <p><input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain/numbness/tingling in:</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Arm(s)/Shoulder</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Elbow(s)</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Wrist/hand</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Leg(s)</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Hips</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Knees</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Ankles</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Feet</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis/bursitis/tendonitis:</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Arm(s)/Shoulder</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Elbow(s)</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Wrist/hand</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Leg(s)</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Hips</p> <p style="padding-left: 20px;"><input type="checkbox"/> <input type="checkbox"/> Knees</p>	<p><b>Reproductive:</b></p> <p><b>Women</b></p> <p><b>P C</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> <input type="checkbox"/> Cramps or pain with menses</p> <p><input type="checkbox"/> <input type="checkbox"/> PMS</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular cycles</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive menstrual flow</p> <p><input type="checkbox"/> <input type="checkbox"/> Lumps/cysts in breast</p> <p><input type="checkbox"/> <input type="checkbox"/> Uterine fibroids</p> <p><input type="checkbox"/> <input type="checkbox"/> Endometriosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ovarian cysts</p> <p><input type="checkbox"/> <input type="checkbox"/> Yeast infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> <input type="checkbox"/> Low libido (sex drive)</p> <p><b>Men</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Dribbling</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficult urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Testicular pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Erectile dysfunction</p> <p><input type="checkbox"/> <input type="checkbox"/> Low libido (sex drive)</p> <p><input type="checkbox"/> <input type="checkbox"/> Hernias</p>
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**VII. Social History**

Live:  alone  Roommate(s)  Significant other (\_\_\_\_years)

Children (names and ages \_\_\_\_\_)

Do you enjoy your job?  yes  no If no, why? \_\_\_\_\_

How many hours per week do you work? \_\_\_\_\_. Do you allow time to unwind/relax? yes  no.

Do you have the support of friends and family concerning your health choices?  yes  no

What is your daily stress level?  very high  high  moderate  slight  none

**Detoxification:**

Have you ever lived/traveled outside of the United States?  yes  no

Did you get sick while you were there or after returning?  yes  no

List any chemicals, solvents, fumes, or mold that you may be exposed to at work or with hobbies: \_\_\_\_\_

List any emotional or personal conflicts that you may be exposed to repeatedly: \_\_\_\_\_

Do you eat large fish (tuna, swordfish, shark, etc) more than twice weekly?  yes  no

**Mental/Emotional:**

Have you ever been treated for or do you have a drug or alcohol problem?  yes  no

Have you ever been treated for or do you have an eating disorder?  yes  no

**Do you generally feel (circle):** Happy Moody Angry Anxious Depressed Alone  
 Are you easily (circle): Weepy Irritable Fearful Nervous Sad Panic/Unable to tolerate stress

**Energy** 1 (none whatsoever) , 10 (abundant)

Morning energy:	1-----5-----10
Midday energy:	1-----5-----10
Evening energy:	1-----5-----10
Average daily:	1-----5-----10
After exercise:	1-----5-----10

**Sleep:**

What time do you go to bed? \_\_\_\_\_PM. What time do you wake? \_\_\_\_\_AM.

How long does it take you to get to sleep: \_\_\_\_\_(minutes).

Number of times you wake: \_\_\_\_\_.

Do you return to slumber if you wake before morning?  yes  no

Do you wake feeling refreshed?  yes  no

Current weight: \_\_\_\_\_ Ideal weight: \_\_\_\_\_ Last time at ideal: \_\_\_\_\_

*Thank you for taking the time to complete this history, although please fill out the 3 Day Diet Recall as well.*

*If you have any questions, please ask!*

**3 Day Diet Recall**

	DAY 1	DAY 2	DAY 3
<b>BREAKFAST</b>			
<b>SNACK</b>			
<b>LUNCH</b>			
<b>SNACK</b>			
<b>DINNER</b>			
<b>DESSERT</b>			
<b>BEVERAGES</b>			
<b>ALCOHOL</b>			
<b>COFFEE/TEA</b>			
<b>NICOTINE</b>			
<b>OTHER</b>			

