

# 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: \_\_\_\_\_

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

Treatments you have received for your main problem: \_\_\_\_\_

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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?

- |                                   |  |  |   |
|-----------------------------------|--|--|---|
| <input type="checkbox"/> measles  | <input type="checkbox"/> mumps         | <input type="checkbox"/> chicken pox     | <input type="checkbox"/> whooping cough |
| <input type="checkbox"/> polio    | <input type="checkbox"/> diphtheria    | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> scarlet fever  |
| <input type="checkbox"/> smallpox | <input type="checkbox"/> typhoid fever | <input type="checkbox"/> 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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

	Living (age)	Family History 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?

- |                                       |   |  |                                       |
|---------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> allergies    | <input type="checkbox"/> arthritis          | <input type="checkbox"/> asthma              | <input type="checkbox"/> cancer       |
| <input type="checkbox"/> diabetes     | <input type="checkbox"/> anemia             | <input type="checkbox"/> depression          | <input type="checkbox"/> skin disease |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> genetic problem    | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke       |
| <input type="checkbox"/> ulcers       | <input type="checkbox"/> cataracts          | <input type="checkbox"/> thyroid problems    | <input type="checkbox"/> hypoglycemia |
| <input type="checkbox"/> seizures     | <input type="checkbox"/> sickle cell anemia | <input type="checkbox"/> 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? \_\_\_\_\_

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