Patient History & Symptom Review

Complete this questionnaire as thoroughly as possible in order to aid in your diagnosis and treatment. This is a confidential record and will be kept in this office. Information contained herein will not be released to any person except when you have authorized us to do so.

Name ____ Date ________________

Street ______________________________________ Primary Phone ________________

City____________________ St ____ Zip __________ Secondary Phone________________

E-mail address ____

Age _______ DOB ____________ ☐ M ☐ F ☐ Other Height __________ Weight __________

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Live Alone

Employer ______________________________ Occupation___________________________

Name of person we should contact in event of an emergency:

Name/Relationship ______________________________ Phone ______________________

How were you referred to this clinic? ____

Who is your primary care doctor? ____

Are you currently under the care of another health care provider? If so, who is it and what type of care?

____

MAIN REASON FOR COMING ____

____

When did it begin? (Date) __________ What caused it? ______________________________

Work-related? ☐ Y ☐ N ☐ DK Accident? ☐ Y ☐ N What kind? ______________________

What makes it better? ☐ heat ☐ cold ☐ activity ☐ rest ☐ other ______________________

What makes it worse? ☐ heat ☐ cold ☐ activity ☐ rest ☐ other ______________________

Is it getting worse? ☐ Y ☐ N Does it interfere with? ☐ work ☐ sleep ☐ daily routine

Have you received treatment for this problem? ☐ Y ☐ N If yes:

Who?	When?	Treatment	Did it help?
____________	________	______________________	☐ Y ☐ N
____________	________	______________________	☐ Y ☐ N

OTHER HEALTH CONCERNS, GOALS, or DIAGNOSES:

1. ____
2. ____
3. ____

OTHER HEALTH ISSUES/GOALS:

□ Improve energy levels □ Gain or lose weight □ Improve immunity □ Clear skin □ Improve diet/nutrition
□ Detoxification □ Pain management □ Balance hormones □ Balance moods □ Other_______________________
□ Manage chronic illness____
□ Reduce reliance on ____________________________ (caffeine, tobacco, alcohol, sleep aids, recreational drugs, etc.)

OVERALL HEALTH:

Considering your age, how would you describe your overall health? □ Excellent □ Good □ Fair □ Poor
In general, how satisfied are you with your life? □ Very satisfied □ Mostly satisfied □ Mostly disappointed

PERSONAL HEALTH HISTORY:

Have you ever had the following illnesses or Injuries? Check all that apply:

□ Allergies/hay fever	□ Diabetes	□ Hypoglycemia	□ Polio
□ Anemia	□ Diphtheria	□ Influenza	□ Prostate problems
□ Arthritis/gout	□ Dislocations	□ Kidney/bladder problems	□ Psoriasis
□ Asthma	□ Diverticulitis	□ Lifting injuries	□ Rheumatic fever
□ Auto accident/injury	□ Eczema/hives	□ Measles	□ Scarlet fever
□ Autoimmune disease	□ Emphysema/COPD	□ Migraines	□ Shingles
□ Bleeding/bruising	□ Food/chemical/drug poisoning	□ Mononucleosis	□ Sprains
□ Broken bones	□ Frequent infections	□ Mumps	□ Stroke
□ Bronchitis	□ Gallstones/gallbladder disease	□ Neuritis or neuralgia	□ Thyroid problems
□ Cancer	□ Heart disease	□ Osteoporosis	□ Tuberculosis
□ Chicken pox	□ Hepatitis A B C	□ Paralysis	□ Ulcers/gastritis/GERD
□ Colitis or bowel disease	□ Herpes	□ Pleurisy	□ Venereal disease/STD
□ Concussion	□ High blood pressure	□ Pneumonia	□ Whooping cough
□ Convulsions/epilepsy	□ High cholesterol	□ Parasitic infection	

When was your last:

Physical exam:	Date _______________	Results ____
Blood test:	Date _______________	Results ____
Chest X-ray:	Date _______________	Results ____
Skin exam:	Date _______________	Results ____
EKG:	Date _______________	Results ____
Colonoscopy	Date _______________	Results ____
Other:___________	Date _______________	Results ____

ALLERGIES/SENSITIVITIES: Check all that apply.

□ No known or suspected allergies or sensitivities

Inhalant: □ Dust □ Fumes □ Grass □ Molds □ Pets □ Pollen □ Smoke □ Trees □ Weeds □ Other __________
Foods: □ Wheat/gluten □ Alcohol □ Citrus □ Dairy □ Peanuts □ Nuts □ Soy □ Other _____________________
Medications: Antibiotics □ Aspirin □ Codeine or morphine □ Penicillin □ Other ___________________________

HOSPITALIZATIONS/SURGERIES: Have you been hospitalized for any illness? ☐ Y ☐ N

Reason ____ Month/Year_________ Where __________________________

Reason ____ Month/Year_________ Where __________________________

Have you ever had surgery? Give year or age:

Tonsils_______________ Appendix_______________ Hysterectomy _____________ Gall bladder ________________

Kidney_______________ Heart _________________ Hernia ___________________ Back/spine _________________

Prostate______________ Cyst __________________ Cancer ___________________ Breast _____________________

Other ____

Have you ever had a blood or plasma transfusion? ☐ Y ☐ N Do you know your blood type? ☐ O ☐ A ☐ B ☐ AB ☐ No

FOREIGN TRAVEL IN THE PAST TEN YEARS:

Location ____________________________ Year _______ Location _______________________________ Year ______

FAMILY HISTORY

If Living:			If Deceased:		Has any blood relative ever had…? Who?
	Age	Health	Age	Death Cause	
Father	______	______________	______	______________________	Cancer ___________________________
Mother	______	______________	______	______________________	Tuberculosis _____________________
Sibling	______	______________	______	______________________	Diabetes _________________________
Sibling	______	______________	______	______________________	Heart trouble ____________________
Sibling	______	______________	______	______________________	High blood pressure _______________
Sig. other	______	______________	______	______________________	Stroke ___________________________
Children	______	______________	______	______________________	Epilepsy _________________________
Children	______	______________	______	______________________	Suicide __________________________

EXERCISE:

I enjoy exercising _________ days/week. Activities:____

Are you satisfied with your level of fitness? ☐ Y ☐ N

What physical activities do you enjoy doing or are interested in?____

How do you play? ____

ENERGY: Please indicate your level of energy throughout the day using scale of 1-10 (1 is lowest, 10 is highest)

Waking________ Lowest________ Time of day______________ Highest________ Time of day___________

SLEEP:

How many hours of sleep do you usually get a night? __________________Any trouble falling or staying asleep?__________

Please describe: ____

Do you need sleep aids? ☐ Y ☐ N What kind? ____

Do you wake feeling refreshed? ☐ Always ☐ Usually ☐ Rarely ☐ Never

ADVERSE REACTIONS TO MEDICATIONS OR SUBSTANCES: Please describe any adverse reactions you have experienced to:

- ☐ Prescription or over-the-counter drugs ____
- ☐ Recreational drugs ____
- ☐ Vaccinations ____
- ☐ Herbs or vitamins ____

REVIEW OF SYSTEMS

If you have the symptoms below, please check the box that best describes their severity. If you don't have symptoms, leave blank.
Please circle your response if the symptom is current. 1 = mild/sometimes 2 = moderate/often 3 = severe/constant

GENERAL	1	2	3		1	2	3		1	2	3
Unintentional weight loss	☐	☐	☐	Difficulty sleeping	☐	☐	☐	Feel warmer than others	☐	☐	☐
Unexplained fevers	☐	☐	☐	Strong thirst	☐	☐	☐	Feel colder than others	☐	☐	☐
Swollen lymph nodes	☐	☐	☐	Night sweats	☐	☐	☐	Vertigo or dizziness	☐	☐	☐
Unusual/unexplained fatigue	☐	☐	☐	Change in appetite	☐	☐	☐	Accident prone	☐	☐	☐
Unusual/increased bleeding	☐	☐	☐	Unusual skin rash	☐	☐	☐				

MUSCULOSKELETAL	1	2	3		1	2	3		1	2	3
Aching muscles or joints	☐	☐	☐	Numbness	☐	☐	☐	Neck pain	☐	☐	☐
Joint pain or swelling	☐	☐	☐	Tingling	☐	☐	☐	Low back pain	☐	☐	☐
Bones painful or sore	☐	☐	☐	Problems walking	☐	☐	☐	Tremors	☐	☐	☐
Painful fingers	☐	☐	☐	Cannot sit straight	☐	☐	☐	Muscle jerking	☐	☐	☐
Painful feet	☐	☐	☐	Loss in height	☐	☐	☐	Leg cramps	☐	☐	☐
Weakness in arms or legs	☐	☐	☐	Elbow pain	☐	☐	☐	Wrist pain	☐	☐	☐
Knee pain	☐	☐	☐	Hip pain	☐	☐	☐	Headaches	☐	☐	☐
Shoulder pain	☐	☐	☐								

EYE/EAR/NOSE/THROAT	1	2	3		1	2	3		1	2	3
Eye pain or itching	☐	☐	☐	Ringing in ears	☐	☐	☐	Difficulty swallowing	☐	☐	☐
Blurry vision	☐	☐	☐	Hearing loss	☐	☐	☐	Pain on swallowing	☐	☐	☐
Double vision	☐	☐	☐	Ear pain or itching	☐	☐	☐	Toothache	☐	☐	☐
See halos or lights	☐	☐	☐	Discharge from ear	☐	☐	☐	Chronic sore tongue	☐	☐	☐
Wear glasses or contacts	☐	☐	☐	Frequent nosebleed	☐	☐	☐	Sore or bleeding gums	☐	☐	☐
Watering eyes	☐	☐	☐	Runny nose	☐	☐	☐	Dry throat	☐	☐	☐
Glaucoma	☐	☐	☐	Nose obstruction	☐	☐	☐	Snoring	☐	☐	☐
Night blindness	☐	☐	☐	Sinus pain	☐	☐	☐	Hoarse voice	☐	☐	☐
Cataracts	☐	☐	☐	Head colds	☐	☐	☐	Swelling in neck	☐	☐	☐
Strange odors or taste	☐	☐	☐	Jaw pain	☐	☐	☐	Sore throat	☐	☐	☐

HEART/CIRCULATION/LUNGS					1	2	3		1	2	3
Difficult breathing	☐	☐	☐	Sit up to breathe	☐	☐	☐	Fainting	☐	☐	☐
Wheezing or gasping	☐	☐	☐	Rapid/skipped beat	☐	☐	☐	Leg cramps	☐	☐	☐
Chronic cough	☐	☐	☐	Swollen feet/ankles	☐	☐	☐	Cramps walking/at night	☐	☐	☐
Cough up blood	☐	☐	☐	Chest pain	☐	☐	☐	Varicose veins	☐	☐	☐
Asthma	☐	☐	☐	Chest pain on effort	☐	☐	☐	Cold hands/feet	☐	☐	☐
Daily sputum production	☐	☐	☐	High blood pressure	☐	☐	☐	Low blood pressure	☐	☐	☐
Catch colds easily	☐	☐	☐	Pounding heartbeat	☐	☐	☐				

THYROID	1	2	3		1	2	3		1	2	3
Swollen or bulging eyes	☐	☐	☐	Gain weight easily	☐	☐	☐	Strong urine scent	☐	☐	☐
Cold hands/feet	☐	☐	☐	Loss of weight	☐	☐	☐	Slow reflexes	☐	☐	☐
Trouble awakening	☐	☐	☐	Dry skin	☐	☐	☐	Thick skin/fingernails	☐	☐	☐

Please circle your response if the symptom is current. 1 = mild/sometimes 2 = moderate/often 3 = severe/constant

GASTROINTESTINAL	1 2 3		1 2 3		1 2 3
Nausea	☐ ☐ ☐	Loss of appetite	☐ ☐ ☐	Gray/whitish stools	☐ ☐ ☐
Heartburn	☐ ☐ ☐	Gas	☐ ☐ ☐	Mucus in stools	☐ ☐ ☐
Frequent belching	☐ ☐ ☐	Bloating	☐ ☐ ☐	Black Tarry stools	☐ ☐ ☐
Vomiting	☐ ☐ ☐	Constipation	☐ ☐ ☐	Rectal itch	☐ ☐ ☐
Stomach pain w/stress	☐ ☐ ☐	Diarrhea/loose stool	☐ ☐ ☐	Rectal pain	☐ ☐ ☐
Fatigue after eating	☐ ☐ ☐	Blood in stools	☐ ☐ ☐	Hemorrhoids	☐ ☐ ☐
Abdominal pain/cramps	☐ ☐ ☐	Change in bowel habits	☐ ☐ ☐	Alt. loose stools/constipation	☐ ☐ ☐

Do you have bowel movements every day? ☐ Y ☐ N How many typically? ___________________

LIVER/GALL BLADDER	1 2 3		1 2 3		1 2 3
Skin turns yellow	☐ ☐ ☐	Sensitive to meds	☐ ☐ ☐	Floating stools	☐ ☐ ☐
Skin itches	☐ ☐ ☐	Insensitive to meds	☐ ☐ ☐	Pain under right ribcage	☐ ☐ ☐
Intolerance of fatty foods	☐ ☐ ☐	Headache after eating	☐ ☐ ☐	Gallstones	☐ ☐ ☐

KIDNEYS & BLADDER	1 2 3		1 2 3		1 2 3
Frequent or excess urination	☐ ☐ ☐	Pain with urination	☐ ☐ ☐	Scanty urine	☐ ☐ ☐
Retention of urine	☐ ☐ ☐	Burning urination	☐ ☐ ☐	Constant urge to urinate	☐ ☐ ☐
Difficulty starting urination	☐ ☐ ☐	Leakage of urine	☐ ☐ ☐	Kidney stones	☐ ☐ ☐
Wake up to urinate	☐ ☐ ☐	How many times/night?__________		Brown/black/bloody urine	☐ ☐ ☐

SKIN	1 2 3		1 2 3		1 2 3
Rashes	☐ ☐ ☐	Hives	☐ ☐ ☐	Hair loss	☐ ☐ ☐
Acne	☐ ☐ ☐	Ulcerations	☐ ☐ ☐	Bruise easily	☐ ☐ ☐
Eczema	☐ ☐ ☐	Dandruff	☐ ☐ ☐	Psoriasis	☐ ☐ ☐
Itching	☐ ☐ ☐	Hot flashes	☐ ☐ ☐	Excess sweating	☐ ☐ ☐

Any recent skin or hair changes?____

Any unusual skin problems or sores that will not heal? Where? ______________________________

EMOTIONS	1 2 3		1 2 3		1 2 3
Anxiety	☐ ☐ ☐	Hopeless outlook	☐ ☐ ☐	Poor memory	☐ ☐ ☐
Depression	☐ ☐ ☐	Lonely	☐ ☐ ☐	Dislike criticism	☐ ☐ ☐
Bad temper	☐ ☐ ☐	Easily stressed	☐ ☐ ☐	Nervousness	☐ ☐ ☐

Have you ever attempted suicide? ☐ Y ☐ N ____

How close are your social ties with family and friends? ☐ Very close ☐ Somewhat close ☐ Somewhat distant ☐ Very distant

Satisfied in your current relationship? ☐ Y ☐ N ☐ N/A Are you currently involved in an abusive relationship? ☐ Y ☐ N

Have you been physically, sexually or emotionally abused in the past? ☐ Y ☐ N ________________________

Have you ever been treated for mental or emotional problems? ☐ Y ☐ N __________________________

MEN'S HEALTH	1 2 3		1 2 3		1 2 3
Premature ejaculation	☐ ☐ ☐	Low sex drive	☐ ☐ ☐	Erection problems	☐ ☐ ☐
Painful testicles	☐ ☐ ☐	Ejaculation pain	☐ ☐ ☐	Sores on genitals	☐ ☐ ☐
Lumps/swelling on testicles	☐ ☐ ☐	Prostate problems	☐ ☐ ☐	Burning in penis	☐ ☐ ☐
Varicose veins in scrotum	☐ ☐ ☐	Low sperm count	☐ ☐ ☐	Discharge from penis	☐ ☐ ☐

Last PSA test: Date_________ Result: ____________ Last prostate exam: Date_________ Result:____________________

Do you do regular scrotum self exams? ☐ Y ☐ N How often? ____________________________

PERSONAL HABITS Please indicate if you use any of the following: Circle Y (Yes), N (No), or P (Past)

Tobacco Y N P # of Cigarettes or Packs/Day____________ Other Tobacco? ______________________________

Caffeine Y N P # Cups of Coffee/Day_________________ Other caffeine sources? _______________________

Alcohol Y N P # Drinks/week (1 beer= 12 oz; 1 wine= 5oz; 1.5 oz hard alcohol) ______________________________

Soda Y N P Ounces/day __________________________

WOMEN'S HEALTH

MENSTRUAL HISTORY: Age at first menses: ______ Age at last menses:_______ Date of most recent period ______________

Are your periods regular? ☐ Y ☐ N Days between periods____________________ Period lasts _________________ days

Do you use: ☐ tampons? ☐ pads? ☐ cup/keeper? # used/day & size: ___________ Bleeding is: ☐ light ☐ medium ☐ heavy

Do you bleed: Between periods? ☐ Y ☐ N Do you have painful periods? ☐ Y ☐ N Is it: ☐ mild? ☐ moderate? ☐ severe?

Do you/have you had pelvic inflammatory disease? ☐ Y ☐ N Do you have recurrent vaginal/bladder infections? ☐ Y ☐ N

Have you been diagnosed with endometriosis? ☐ Y ☐ N Do you have Polycystic Ovarian Syndrome? ☐ Y ☐ N

Do you have unusual vaginal discharge? ☐ Y ☐ N Describe (color/consistency/odor) _________________________________

When was your last: Gyn exam?____________ Pap? ____________ Breast exam?____________ Mammogram?____________

Thermogram?____________ Bone Density Scan?____________

Have you ever had an abnormal Pap or cervical dysplasia? Describe____

Have you ever had an abnormal mammogram? Describe____

Do you perform regular breast self-exams? ☐ Y ☐ N How often?________ Breast masses? ☐ Y ☐ N Nipple discharge? ☐ Y ☐ N

Have you been told you are going through or have you gone through menopause? ☐ Y ☐ N

Is Premenstrual Syndrome (PMS) a health issue for you? ☐ Y ☐ N Is your sex drive: ☐ normal? ☐ low? ☐ high?

Have you ever been on hormone replacement therapy? When/Age:____

MENSTRUAL & MENOPAUSAL SYMPTOMS: 1 = mild/sometimes 2 = moderate/often 3 = severe/constant

	1 2 3		1 2 3		1 2 3
Night sweats	☐ ☐ ☐	Abdominal bloating	☐ ☐ ☐	Depression	☐ ☐ ☐
Mood swings	☐ ☐ ☐	Headache	☐ ☐ ☐	Forgetfulness	☐ ☐ ☐
Irritability	☐ ☐ ☐	Sweet cravings	☐ ☐ ☐	Crying	☐ ☐ ☐
Anxiety/Nervous tension	☐ ☐ ☐	Increased appetite	☐ ☐ ☐	Confusion	☐ ☐ ☐
Weight gain	☐ ☐ ☐	Heart pounding	☐ ☐ ☐	Insomnia	☐ ☐ ☐
Fatigue	☐ ☐ ☐	Breast tenderness	☐ ☐ ☐	Swollen hands/feet	☐ ☐ ☐
Acne	☐ ☐ ☐	Hot flashes	☐ ☐ ☐	Dizziness/faintness	☐ ☐ ☐

BIRTH CONTROL: What methods of birth control are you now using or have used in the past? Check all that apply.

☐ None ☐ Not applicable Birth control pills: ☐ Now ☐ Past: When taken? _______________

IUD: ☐ Now ☐ Past: When?________ Kind?___________ Condoms: ☐ Now ☐ Past Cervical cap: ☐ Now ☐ Past

Hormone injection/Nuvaring: ☐ Now ☐ Past Foam: ☐ Now ☐ Past Tubal ligation: ☐ Now ☐ Past

Rhythm method: ☐ Now ☐ Past Fertility Awareness: ☐ Now ☐ Past Partner is sterile or vasectomy: ☐ Now ☐ Past

FERTILITY, PREGNANCY & BIRTH HISTORY:

Any challenges becoming pregnant? ________ Have you ever used any fertility drugs? _________ Procedures? ☐ IUI ☐ IVF

# of pregnancies _______ # of live births _______ # of miscarriages _______ Type of delivery: Vaginal _______ Caesarean _______

Did you breast feed your babies? ☐ Y ☐ N For how long?____

SEXUAL HEALTH:

Are you currently sexually active? ☐ Y ☐ N Partners: ☐ Men ☐ Women ☐ 1 partner/monogamous ☐ >1 partner

Any history of sexually transmitted infections? Please check all that apply: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis

☐ HPV (via Pap) ☐ Genital herpes ☐ Genital warts ☐ Trichomoniasis ☐ HIV

MEDICATIONS and SUPPLEMENTS:

Do you take or have you taken any of the following on a regular basis? Circle Y (Yes), N (No), or P (Past)

Antacids : Y N P   Pain Killers: Y N P   Anti-Inflammatory Med: Y N P   Laxatives: Y N P   Steroids: Y N P

Current Medications	Dosage	For What?	How Long?

Current Vitamins/Minerals	Dosage	For What?	How Long?

Herbs/Homeopathic Meds	Dosage	For What?	How Long?

DIET & NUTRITION:

How many servings of fruits and vegetables do you eat daily? ___________ How often do you eat red meat? ___________

Do you eat organic foods?: All the time______ Often______ Occasionally______ Rarely ______ Never ______

Please describe a typical day's meals:

Breakfast ____

Lunch ____

Dinner ____

Snacks____

Liquids ____

How much water do you drink in a typical day (ounces)? ____________________________

Are you following a current diet (eg, South Beach, Paleo, blood-type, vegan, etc)? ____________________

What types of foods do you crave? ____________________________________

What types of foods do you avoid and why? ____________________________________

____

____

As an adult, what is the most you've ever weighed? ______________ What is the least you've ever weighed? ___________

SOCIAL HISTORY:

Do you have a spiritual practice? _____________________ Support structure? ____________________________

Do you have a social network? ______________________ Hobbies? ____________________________

What brings you the most joy? ____

Thank you for taking the time to fill out this intake form. We know it's comprehensive, but by gathering as much information as possible about your health history and goals, it helps our naturopathic doctors have a more complete understanding of you so that we find the best solutions faster.

Is there is there any other information that you would like your doctor to know about you or any questions you may have?

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We look forward to being your partner on your journey to wellness!