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North Coast Family Health
Naturopathic Medicine

www.naturopathic-doctors.com

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Patient Information (The following information is confidential for Doctor's use only) Date_____/_____/_____

Name_____ Birthdate: _____ Age: ____ Sex _____

Address_____ _____ _____ _____
Street City State Zip

Home Phone_____ Work Phone: _____ Cell: _____

Fax: _____ Email Address: _____ SSN_____

How did you learn about us? _____

Employer/Occupation: _____

Live with: Spouse ____ Partner ____ Parents ____ Relatives ____ Pets ____ Alone ____ Children: ____ Ages _____

Emergency contact: _____ _____ _____
Name Phone Relation

Doctors you are currently seeing (Please include phone numbers):

_____

_____

*** Payment for services and pharmacy are expected at time of visit. Please bring Insurance card to your first appointment.** To help you get what you need in a timely manner, we ask that we keep your credit card information on file. This information will be kept confidential, as is all patient information, and we will not charge your card without notifying you.

I hereby authorize North Coast Family Health to keep my signature and credit card information on file, and to charge my credit card for services rendered to me.

Credit Card #: _____ Exp.: _____ CVV Code: _____

Name on Card: _____ Address (if different): _____

Signature: _____ Date: _____

PLEASE LIST YOUR HEALTH CONCERNS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Current Medicines: (Please be specific with dosages)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Current Supplements (Please be specific with dosages)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are you allergic to any medicines or other substances? _____ If yes, please list:

_____

_____

A NOTE TO OUR PATIENTS: Holistic and Preventive Health Care is only possible when the doctor has a complete picture of the client physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. You may want to consider copying it for you own future records.

Review of Systems
Please indicate the following: **C** = Current Condition, **P** = Past Condition

Skin:
Dry _____
Oily _____
Itching _____
Rashes _____
Hives _____
Flushes Easily _____
Fungal Infections _____
Bruises Easily _____
Warts _____
Moles _____
Where _____
How Many _____
Hair Loss _____
Nails: Soft _____ Breaks _____
Do you bite your nails? _____

Head
Migraines _____
Headaches _____
Location of pain _____
Makes Worse:
Light ____ Noise ____ Odors ____
Head Injury _____
Describe _____

TMJ _____
Dizziness _____
Fainting _____
Seizures _____

Eyes
Vision Disturbances _____
Dryness _____
Tearing _____
Pain _____
Styes _____
Infections _____
Sensitive to light _____

Ears
Discharge _____
Pain _____
Impaired Hearing _____
Ringing _____

Nose
Seasonal Allergies _____
Drainage _____
Color:
Clear ____ Yellow _____ Green ____
Texture: Runny _____ Thick _____
Post Nasal Drip _____
Clears throat often _____
Stuffiness _____
Sneezing _____
Sinus Infection _____
Nosebleeds _____

Mouth
Dryness _____ Salivation _____
Tongue: Sore _____ Coated _____
Canker Sores _____
Fever Blisters _____
Thirst: High _____ Low _____
For: Hot ____ Warm ____ Cool ____
Cold ____ Ice Cold____

Throat/Neck
Pain in Throat _____
Glands Enlarged _____
Difficulty Swallowing _____
Change in Voice _____

Respiratory
Pneumonia _____
How many times? _____
What side? _____
Bronchitis _____
Cough _____
Spit up Blood _____ Mucous _____
Asthma _____ Wheezing _____
Shortness of Breath_____
Positive TB Test? _____

Cardiovascular
Chest Pain _____
Heart Palpitations _____
Heart Disease _____
Blood Pressure:
High _____ Low _____
Varicose Veins _____
Leg Pain _____
Cramps _____
Ankle Swelling _____
Cold Hands _____
Cold Feet _____
Warm _____ Cold_____ Blooded
Perspires _____
Where? _____
Odor? _____ Yes/No

Digestion
Bowel Movement
x per day: _____
x per week: _____
Size: Sm _____ Med _____ Lg _____
Color: _____
Texture: Dry _____ Hard _____
Wet/Loose _____ Pellets _____
Float _____ Sink _____
Stools with Mucous ____ Blood ____
Hemorrhoids _____
Bleeding _____
Painful _____
Itching _____
Sores _____
Stool Incontinence _____
Bowel Disease _____
Liver/Gallbladder Disease _____
Ulcer _____
Heartburn _____
Bloating _____
Belching _____
Gas/Flatus _____
Nausea/Vomiting _____
Pains/Cramps _____

Urinary
Difficult Urination _____
Painful Urination _____
Incontinence/Dribbling _____
Blood in Urine _____
Frequent Urination _____
When? _____
Frequent Bladder Infections _____
Bedwetting _____

Muscular/Skeletal
Back Pain _____
Pain in Muscles/Joints/Bones ____
Stiffness/Swelling _____
Muscle Weakness/Tremor _____
Numbness/Tingling _____
Shooting Pain _____
Paralysis _____
Any side worse: R _____ L _____
Broken Bones? _____
Which _____
Sprained joints? _____ _____
Which _____

General
Fatigue _____
Weight Changes _____
Change in Appetite ___ Thirst ___
Frequent Colds/Infections _____
Date of last Physical _____

Women Only

Date of Last Pelvic Exam _____
Date/Results of Last Pelvic Exam _____
Ever have an abnormal Pap Smear? _____
DES Exposure _____
Sexually Transmitted Disease _____
History of Sexual Abuse _____
Frequent Yeast Infections _____
Vaginal Discharge _____
Age Period Began _____
Regular Periods: _____
Flow: _____
Spotting _____
Cramps _____
PMS? _____ Endometriosis? _____
Fibroids _____ Pelvic Inflammatory Disease _____
Date of last period _____
Ever use birth control pills? _____
How long ago? _____
For how long? _____
Present birth control _____
Change in sex drive? _____
Painful intercourse _____
Pregnancies # _____
Childbirth # _____
Miscarriage # _____
Abortion # _____

Impaired Fertility _____
Have you had a hysterectomy? _____ If yes: _____
Have you had breast cancer? _____
Age at Menopause _____
Vaginal Dryness _____
Hot flashes _____
Sexual Preference: Men____ Women____ Both ____

Men Only

Date of last prostate exam _____
Prostate Enlargement _____
Change in Force of Urine Stream _____
Difficulty Starting Urination _____
Do you do self-testicular exams? _____
Pain/lump in scrotum _____
Discharge from penis _____
Painful intercourse _____
Difficulty with erections _____
Change in sex drive _____
Impaired fertility _____
DES Exposure _____
Sexually Transmitted Disease _____
History of sexual abuse _____
Sexual Preference: Women ____ Men ____ Both ____

Sleep

Do you have difficulty falling asleep? _____
Do you frequently wake? _____
How much sleep do you average a night? (hours) _____
Nightmares/Night Terrors? _____
Do you wake-up feeling refreshed? _____
Do you stick you feet outside the covers? _____

Do you have recurrent dreams? _____
If yes, please describe the theme in one sentence:

Do you wear socks to bed? _____

Family History

Please indicate the following: **M** = Mother **F** = Father **S** = Sister(s) **B** = Brother(s) **G** = Grandparents

Blood Disorders _____
Hemophilia _____
Anemia _____
Thalessemia (Mediterranean Anemia) _____
Alcoholism / Drug Abuse _____
Allergies _____
Alzheimer's Disease _____
Asthma _____
Birth Defects _____
Cancer: _____
  Colon _____
  Breast _____
  Lung _____
  Skin _____
  Other _____
  Prostate _____

Diabetes _____
Eczema _____
Glaucoma _____
Heart Attack _____
Heart Disease _____
High Blood Pressure _____
High Cholesterol _____
Mental Illness _____
Migraines _____
Osteoporosis _____
Parkinsonism _____
Stroke _____
Seizure Disorder _____
Sexual Abuse _____
Sexually Transmitted Disease ____
Skin Disorders _____

Suicide _____
Thyroid Disorder _____
Tuberculosis (TB) _____
Other _____
Other _____

MEDICAL HISTORY

Have you ever had any of the following? If so, please check (X), indicate approximate date of onset and elaborate below if necessary.

____ AIDS or HIV infection
____ Allergies
____ Anemia
____ Antibiotic Use
____ Appendicitis
____ Arthritis
____Asthma
____ Attempted Suicide
____ Back Problems
____ Bladder Infections
____ Bone or Joint Disease
____ Bursitis
____ Cancer
____ Cataracts
____ Chickenpox
____ Chronic Fatigue Syndrome
____ Colitis
____ Depression
____ Diabetes
____ Ear Infections
____ Eating Disorder
____ Eczema
____ Edema (Fluid Retention)
____ Emphysema
____ Exposure to toxic Substances
____ Fibromyalgia
____ Gall Bladder Disease
____ German Measles
____ Glaucoma
____ Gout
____ Hay Fever
____ Head Injury
____ Heart Disease
____ Heart Murmur
____ Hemorrhoids
____ Hepatitis
____ Herpes
____ High/Low Blood Pressure
____ High Cholesterol
____ Hives
____ Hypoglycemia
____ Jaundice
____ Kidney Infections
____ Kidney Stones
____ Liver Disease
____ Lyme Disease
____ Measles
____ Migraine Headaches
____ Mononucleosis
____ Mumps
____ Nervous Breakdown
____ Neurological Disorder
____ Parasites
____ Phlebitis
____ Prostatitis
____ Psoriasis
____ Rheumatic Fever
____ Scarlet Fever/Scarlatina
____ Seizure Disorder
____ Sexually Transmitted Disease (chlamydia, warts, herpes, gonorrhea, syphilis)
____ Sinus Infections
____ Steroid Use
____ Stroke
____ Substance Abuse / Addiction
____ Thyroid Disease
____ TIA's (mini-strokes)
____ Tuberculosis (TB)
____ Ulcer
____ Vaginitis
____ Whooping Cough
____ Warts

Other:_____

Have you ever been bitten by a tick? _____
If yes, please estimate the date/s: _____

Do you know of people in your neighborhood who have Lyme Disease? _____

Surgical History

Please include the date, reason, and outcome of past surgeries.

_____
_____
_____
_____

Mental Status

Symptoms: Please mark **1 = MILD, 2 = MODERATE, 3 = SEVERE** next to the following symptoms which apply to you NOW or in the PAST.

NOW	PAST		NOW	PAST	
_____	_____	Afraid when left alone	_____	_____	Mental confusion
_____	_____	Anxiety	_____	_____	Mood Swings
_____	_____	Confident, secure	_____	_____	Organized, neat/clean
_____	_____	Critical to others	_____	_____	Prefer to be left alone, do not seek out company or comfort
_____	_____	Critical of self	_____	_____	Restlessness
_____	_____	Decreased concentration, comprehension	_____	_____	Sensitive to noises
_____	_____	Depression	_____	_____	Shy, timid
_____	_____	Excessive worry	_____	_____	Suicide attempts
_____	_____	Loneliness	_____	_____	Suicidal thoughts
_____	_____	Make many mistakes	_____	_____	Suspicious, jealous
_____	_____	Memory difficulty, forgetting			

Anger
What makes you angry?_____
Do you get angry often/easily? _____ If yes, please explain:

_____

_____

Do you have difficulty expressing anger? _____ If yes, please explain _____

_____

Sadness
What makes you sad?

_____

What do you do when you are sad? _____
Do you cry easily/often? _____

Grief
List major experiences of grief/loss in your life:

_____

_____

Fears
Please indicate your phobias/fears, rating **3 = very strong, 2 = strong, 1 = medium**
Heights _____ Bridges _____ Crowds _____ Water _____ Claustrophobia _____ Dark _____ Spiders _____ Being Alone _____
Public Speaking _____ Flying _____ Thunderstorms _____
Other _____
What fears do you have (Please list)? Are any unmanageable?

_____

_____

_____

Sex
Is your present sex life satisfactory? Are there any known episodes of sexual or physical abuse in your past?

_____

_____

_____

Diet & Health:
Exercise (please include type & frequency) _____
Do you use Tobacco? _____ If yes, how often? _____
Do you use Recreational drugs? _____ If yes, how often? _____
How many meals do you generally eat each day? _____
Where do you usually buy your food? _____
List the primary foods included in your diet?

_____

_____

List the foods you exclude from your diet?

_____

List any of the following (and relative amounts) eaten regularly by you. Coffee, caffeinated teas, highly seasoned foods, preservatives, margarine, artificial sweeteners, sodas, refined foods and other foods you may suspect may be harmful to your health.

_____

_____

Please put a number **ONLY** next to the foods you **CRAVE:**
3 = very strongly 2 = strong 1 = medium
Sweets ___ Chocolate ___ Salt ___ Sour ___ Hot/Spicy ___ Meats ___ Milk ___ Cheese ___ Fats ___ Eggs ___ Butter ___
Potato Chips ___ Vinegar ___ Lemons ___ Pickles ___ Coffee ___ Ice Cream ___ Alcohol ___ Pepper ___ Ice ___ Other ___

List any foods to which you have had any kind of reaction? Please describe the reactions you have had to these foods:

Are you thirsty? _____ Do you like to chew ice? _____

Amount of liquid you drink each day _____What temperature beverage do you prefer? _____

Are you satisfied with your diet as it is now? _____ Why or why not?

Description of Childhood:

Is there anything about your present behavior that you would like to change? What do you feel is your major mental and/or emotional limitation?

Self-Description:

In 1-2 paragraphs, write a short description of yourself as you see yourself currently. Include strengths, weaknesses, major personality characteristics.

Thank you for your patience, time, and cooperation!