



Please list any vitamins, minerals, herbs or homeopathic remedies that you are presently taking:

Name of supplement	Dose	Reason for taking	For how long	Who prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list your current health care providers:

Name	Type	For what reason	Phone (if available)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations, Serious Illnesses and Injuries: (Please list reason and dates, excluding non-surgical childbirth)

\_\_\_\_\_

\_\_\_\_\_

Date of last full physical exam: \_\_\_\_\_ Results: normal other \_\_\_\_\_

Date of last blood work: \_\_\_\_\_ Results: normal other \_\_\_\_\_

(Females) Are you pregnant, or is there any *chance* that you are pregnant? \_\_\_\_\_

Do you have any surgical implants? If so, what type and where in your body? \_\_\_\_\_

Have you seen a naturopath before? \_\_\_\_\_ If so, how many other naturopaths have you seen? \_\_\_\_\_

How long have you been interested in natural medicine? \_\_\_\_\_

**Lifestyle Habits:**

Tobacco (currently): None Daily Weekly Monthly Amount? \_\_\_\_\_

Do you any history of smoking? If so, how many years? What years? \_\_\_\_\_

Coffee: None Daily Weekly Monthly Amount? \_\_\_\_\_

Black tea: None Daily Weekly Monthly Amount? \_\_\_\_\_

Soft drinks: None Daily Weekly Monthly Amount? \_\_\_\_\_

Alcohol: None Daily Weekly Monthly Amount? \_\_\_\_\_

History of significant alcohol consumption or alcoholism? \_\_\_\_\_ How long and how much? \_\_\_\_\_

Recreational drugs: None Daily Weekly Monthly Amount? \_\_\_\_\_

History of significant recreational drug use? \_\_\_\_\_

Exercise: None Daily Weekly Monthly Amount? \_\_\_\_\_

Are you currently sexually active? \_\_\_\_\_ How do you rate your libido on a scale of 0-10 (optional)? \_\_\_\_\_

**Diet:**

Please describe your typical diet (breakfast, lunch, and dinner), including any guidelines or restrictions that you follow:

**Breakfast:**

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**Lunch:**

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**Dinner:**

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Do you have a gas stove or electric stove at home? \_\_\_\_\_

How often do you eat fish (How many times per week or per month)? \_\_\_\_\_

Do you have a sweet tooth? \_\_\_\_\_

Do you chew gum often, and how often? \_\_\_\_\_

Do you use artificial sweeteners such as Splenda? Which ones? \_\_\_\_\_

(Optional) Please describe briefly your religious and/or spiritual background/beliefs: \_\_\_\_\_

**SEAM Questions (Sleep, Energy, Appetite, and Mood)**

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**Sleep:**

Hours of sleep per night? \_\_\_\_\_

Any problems with sleep? \_\_\_\_\_

How often in a week do you wake up feeling refreshed? \_\_\_\_\_

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**Energy:**

Energy level on a scale of 1-10 (1 is you cannot get up, 10 is optimal full energy)?

\_\_\_\_\_

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**Appetite:**

How is your appetite on a scale of 0-10? (zero is you have no appetite, 10 is voracious appetite)?

\_\_\_\_\_

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**Mood:**

How would you describe your day-to-day mood?

\_\_\_\_\_

**What is your overall sense of well-being?**

\_\_\_\_\_

# PATIENT PROFILE (PLEASE ANSWER CAREFULLY.)

## REVIEW OF SYSTEMS:

Y = Now

P = Past

For the following, PLEASE CIRCLE, or fill in blanks. "Y" means you have the condition now. "P" means that you had the condition in the past, but not any more. If you have never had a condition, leave it blank.

### GENERAL

Height \_\_\_\_\_  
 Weight \_\_\_\_\_  
 Weight changes Y P  
 Night Sweats Y P  
 Fatigue Y P  
 Fever Y P

Frequent sore throat Y P  
 Sore tongue Y P  
 Sores in mouth /on lips Y P  
 Gum problems Y P  
 Hoarseness Y P  
 Dental Problems Y P

### SKIN

Acne Y P  
 Eczema Y P  
 Hives Y P  
 Rashes Y P  
 Infection Y P  
 Growths (such as warts) Y P  
 Changes in hair/nails Y P  
 Transdermal skin patches? \_\_\_\_\_

Fake teeth? How many?  
 How many amalgam (mercury) fillings?  
 Dental implants?  
 If yes, what type?  
 Dental bridges or partial bridges?  
 If so, are they metallic?  
 Any metal of any kind in your mouth?

### MENTAL / EMOTIONAL

Depression Y P  
 Mood Swings Y P  
 Anxiety or nervousness Y P  
 Tension Y P  
 Suicide thoughts Y P  
 Suicide attempts Y P

### HEAD

Headache Y P  
 Head Injury Y P

### EYES

Dryness Y P  
 Glasses or contacts Y P  
 Eye pain Y P  
 Tearing Y P  
 Double vision Y P

### ENDOCRINE

Ever had any thyroid problem Y P  
 Heat or cold intolerance Y P  
 Hypoglycemia Y P  
 Excessive thirst Y P  
 Excessive hunger Y P  
 Easy weight gain Y P

### EARS

Impaired hearing Y P  
 Ringing (tinnitus) Y P  
 Ear ache/itch Y P  
 Dizziness Y P

### CIRCULATION

Deep leg pain Y P  
 Cold hands/ feet Y P  
 Varicose veins Y P

### NOSE & SINUSES

Frequent colds Y P  
 Nose bleeds Y P  
 Stuffiness Y P  
 Sinus problems Y P  
 Post nasal drip Y P

### BLOOD

Anemia Y P  
 Easy bleeding or bruising Y P

### MOUTH & THROAT

### HEART

Heart disease Y P  
 High blood pressure Y P

Rheumatic fever	Y	P
Chest pain	Y	P
Swelling in ankles	Y	P
Palpitations, fluttering	Y	P

RESPIRATORY

Cough Y P  
 Spitting up blood Y P  
 Wheezing Y P  
 Difficulty breathing Y P  
 Shortness of breath Y P  
 Positive TB test ever? Y P

DIGESTION

Trouble swallowing Y P  
 Heartburn Y P  
Take heartburn or acid reflux medicines?  
 Bloating after eating Y P  
 Change in appetite Y P  
 Change in thirst Y P  
 Loose stools Y P  
 Blood in stools Y P  
 Belching or gas Y P  
 Liver/gall bladder disease Y P  
 Hemorrhoids Y P  
 Nausea Y P  
 Vomiting Y P  
 Bowels move: daily more less  
 Use laxatives? What kind?  
 Eat plenty of fiber?

URINARY

Pain on urination Y P  
 Increased frequency Y P  
 Frequency at night Y P  
 Inability to hold urine Y P  
 Bladder infections Y P  
 Swellings anywhere in body Y P

MUSCULOSKELETAL

Joint pain or stiffness Y P  
 Broken bones Y P  
 Muscle spasms or cramps Y P  
 Muscle spasms or cramps Y P  
 Weakness Y P  
 Date of last DEXA scan?

NEUROLOGIC

Fainting Y P  
 Seizures Y P  
 Paralysis Y P  
 Muscle weakness Y P  
 Numbness or tingling Y P  
 Loss of memory Y P

NECK

Swollen glands Y P  
 Pain or stiffness Y P

MALE

Hernias Y P  
 Testicular masses Y P  
 Testicular pain Y P  
 Discharge or sores Y P  
 Venereal disease Y P  
 Difficulty stopping or starting urination Y P  
 Prostate problems Y P  
 Date of last prostate exam \_\_\_\_\_

FEMALE

Age menses began \_\_\_\_\_  
 No. of days menstrual flow \_\_\_\_\_  
 Length of complete cycle \_\_\_\_\_  
 Are cycles regular Y P  
 Bleeding between periods Y P  
 Excessive flow Y P  
 Cramps Y P  
 PMS Y P  
 Abnormal vaginal discharge Y P  
 DATE of LAST PAP Smear \_\_\_\_\_  
 Results were: normal abnormal don't know  
 EVER had an abnormal PAP? Y P  
 Date of last mammogram? \_\_\_\_\_  
**Ever used birth control pills? Y P**  
**Ever used an IUD? Y P**  
 If so, how long? \_\_\_\_\_  
 No. of pregnancies \_\_\_\_\_  
 No. of live births \_\_\_\_\_  
 No. of miscarriages \_\_\_\_\_  
 No. of abortions \_\_\_\_\_  
 Menopausal symptoms Y P  
 Still have your own uterus? Yes or No?  
 Still have your own ovaries? Yes or No?

BREASTS

Do you self exam regularly Y P  
 Lumps Y P  
 Pain or tenderness Y P  
 Nipple Discharge Y P

**Family History:** Please check the boxes below for each condition that applies to one of your family members.

	Mother	Father	Brother	Sister	Grandparent
Alcoholism					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Mental Illness					
Stroke					
Other significant disease(s)					

**Circle all the diseases/disorders/conditions that apply, and then specify “Now” or “Past”. If both “Now” or “Past” apply, then check both columns.**

<b>Conditions/diseases</b>	<b>NOW</b>	<b>PAST</b>
Acid reflux		
Allergies		
Anemia		
Arthritis, Rheumatoid		
Arthritis, Osteoarthritis		
Asthma		
Atherosclerosis		
ADD or ADHD		
Autoimmune diseases(s)? Which one(s)? (Lupus, MS, RA, myositis, sarcoidosis, etc.)		
Bladder infection		
BPH (Benign Prostatic Hyperplasia)		
Bronchitis		
Cancer, specify type(s)		
Celiac disease		

<b>Conditions/diseases</b>	<b>NOW</b>	<b>PAST</b>
Cholesterol, high or low?		
Constipation		
Crohn's disease		
Diabetes type 1 or 2		
Diarrhea		
Diverticulitis/Diverticulosis		
Endometriosis		
Fibromyalgia		
Fibrocystic Breasts		
Heavy metal toxicity		
Hepatitis, specify type(s)		
Herpes		
High blood pressure (hypertension)		
Hyperthyroidism		
Hypoglycemia		
Hypothyroidism		
IBS		
IBD (Crohn's or Ulcerative colitis)		
Immune system malfunction (poor immune function, etc.)		
Insomnia		
Interstitial cystitis		
Libido (sex drive), low or high		
Kidney stones		
Liver problems (fatty liver, enlarged liver, etc.)		

<b>Conditions/diseases</b>	<b>NOW</b>	<b>PAST</b>
Memory loss or poor memory		
Menopausal symptoms (hot flashes, sweats, etc.)		
Menstrual problems (painful periods, bloating, etc.)		
Migraine headaches		
Obesity		
Osteopenia		
Osteoporosis		
Ovarian cysts		
PMS		
Prostatitis		
Psoriasis		
Restless legs syndrome		
Sciatica		
Shingles		
Sinusitis		
Tachycardia		
Triglycerides, high		
Tuberculosis		
Tumors, benign or malignant?		
Ulcerative colitis		
Uterine fibroids		
Ulcers		
Yeast infections, vaginal or gastrointestinal?		