

Personal Health Questionnaire

All information is strictly confidential. Successful health care and preventative medicine addresses the whole person on a physical, emotional and mental level. Your time, thoughtfulness and honesty will greatly aid us in assisting your health needs.

*(Write or Type at the ‘\*’and click at the . If Mac, we’ll do the  later)*

|  |  |  |  |
| --- | --- | --- | --- |
| Legal Name  \* | Preferred Name (if different)  \* | | Date of Birth  \* |
| Email  \* | Preferred Phone  \* | | Alternate Phone  \* |
| Address  \* | City, State:  \* | | Zip  \* |
| Emergency Contact and Phone  \* | | | Parents name if under 18yo  \* |
| Insurance Company  \* | | How did you hear about us?  \* | |

**What are your long term personal goals for our work together?**

|  |
| --- |
| \* |
|  |
|  |
|  |
|  |
|  |

**Ongoing Concerns (in order of importance)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Concern  *Headaches* |  | Started when?  *June 2010* |  | How often?  *4 per week* |  | How severe?  *mild/mod/severe* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
|  |  |  |  |  |  |  |

*You may list more later on the Health Systems Check-list*

**Context of Your Concerns**

Is there an event, illness, stress where your health has never been the same since?

\*

What behaviors do you engage in that you feel are very supportive to your health goals?

\*

What behaviors do you engage in that you feel are not supportive to your health goals?

\*

Are there things that you feel you should be doing for your health, but aren’t? Why?

\*

How committed are you to making the lifestyle changes necessary to meet your goals?

0% 0 1 2 3 4 5 6 7 8 9 10 100%

Type a value from 1-10

**Tell us about your prior medical history**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospitalizations or Surgeries and Dates |  |  | Allergies (food, environ, meds) |  | Type of Reaction |
| \* |  |  | \* |  | \* |
| \* |  |  | \* |  | \* |
| \* |  |  | \* |  | \* |
| \* |  |  | \* |  | \* |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Illness** | **Past** | **Now** | **Family** | **Who?** | **Other Important Information?** |
| Asthma |  |  |  | \* | \* |
| Autoimmune |  |  |  | \* |
| Cancer |  |  |  | \* |
| Diabetes |  |  |  | \* |
| Digestive Concerns |  |  |  | \* |
| Heart Disease |  |  |  | \* |
| Hepatitis |  |  |  | \* |
| High Blood Pressure |  |  |  | \* |  |
| Lung Disease |  |  |  | \* |  |
| Thyroid Condition |  |  |  | \* |  |
| Neurological |  |  |  | \* |  |
| \* |  |  |  | \* |  |
| \* |  |  |  | \* |  |

What medications are you currently taking? (Both prescriptions and OTC)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Medication and Dose  *Zantac 20mg 2x/day* |  | Reason  *Stomach upset* |  | Started?  *11/2008* |  | Prescribed By  *Alan James, MD* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
|  |  |  |  |  |  |  |

*If you would like, we can provide you with a longer medication and supplement form*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Supplement, Brand and Dose  *Super Vitamin C (Thorne) 500mg / day* |  | Reason  *Immune Support* |  | Started?  *11/2008* |  | Recommended By  *Self* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
| \* |  | \* |  | \* |  | \* |
|  |  |  |  |  |  |  |

Other Healthcare Providers?

\*

Additional Prior Medical History that you would like to share:

\*

**Tell us about how you eat**

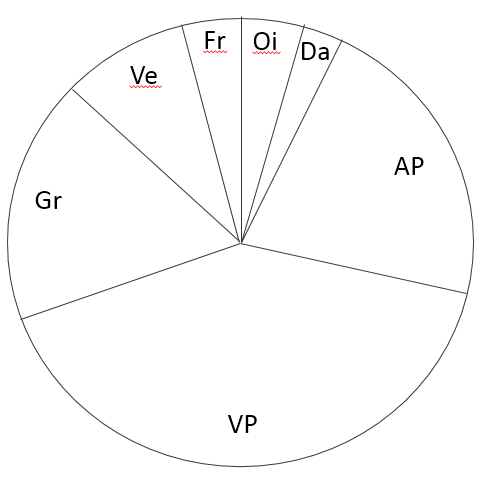
|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Sodas, oz/day | \* |  | Food Sensitivity | \* | | |
| Caffeine, oz/day | \* |  | Food Restrictions | \* | | |
| Water, oz/day | \* |  | Food Ethics | Vegetarian  Vegan  Paleo  Other: | | |
| Alcohol #/day | \* |  |  |  | | |
| Food Cravings | \* |  | Do you eat? | In the car | Watching TV | Standing |
| With others | On the go | In a hurry |
| After 11pm | In your sleep | On waking |
| Snack Foods | \* |  |  |  | | |
| Typical Breakfast | \* |  | How often do you eat out? Where? | | | |
|  | \* |  | \* | | | |
| Typical Lunch | \* |  | Tobacco Use? | Never  Ages \* to \*. \* packs per day | | |
|  | \* |  |  |  | | |
| Typical Dinner | \* |  | Bowel movements per day \*  Constipated? | | | |
|  | \* |  | Any Bowel Concerns? \* | | | |

Diet Chart

Create a pie chart below that roughly describes the distribution of the food groups that you eat a typical daily meal. *(If you’re filling this electronically, we’ll assess in office)*

|  |
| --- |
| □ Vegetable Protein (VP) □ Animal Protein (AP) □ Dairy (Da) □ Grains (Gr) |
| □ Oils and Fats (Oi) □ Vegetables (Ve) □ Fruits (Fr) |

*For example, your chart may look like this:*



**Tell us about your life**

What is your occupation? Do you enjoy it?

\*

What stresses you out in your life?

\*

Do you have supportive relationships?

\*

How is your sleep? Typical bedtime and wake time? Do you wake Rested? Do you Snore?

\*

What do you do to relax? What are your hobbies?

\*

What types of physical activity do you do? How often?

\*

When during the day is your energy the best? Worst?

\*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Height |  | Weight |  | Weight 1 yr ago |  | Max weight (and year) |
| \* |  | \* |  | \* |  | \* |

**Initial Health Systems Check-list**

As a New Patient, please check any items that have concerned you in the last **YEAR**. If it was in the distant past, put ‘P’ next to the item (if handwriting). We will use this sheet to track progress over future visits.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| GENERAL: | FATIGUE | WEIGHT LOSS | MOOD CHANGES | HARDER TIME EXERCISING | HISTORY OF ABUSE |
|  | STRESS | WEIGHT GAIN | INSOMNIA | CHANGES IN STRENGTH | OTHER: |
| ABDOMEN/DIGESTION: | ABDOMINAL PAIN | CONSTIPATION | DIARRHEA | HEART BURN – REFLUX | GAS OR BLOATING |
|  | NAUSEA/VOMITING | APPETITE CHANGES | BLOOD IN STOOL | FOUL ODOR | OTHER: |
| HORMONES: | FATIGUE | TIRED-BUT-WIRED | AFTERNOON CRASH | SALT CRAVING | DIABETES |
|  | HYPOTHYROID | HYPERTHYROID | EXCESSIVE THIRST | COLD INTOLERANCE |  |
|  | 3AM WAKING | DIZZY ON STANDING | EXCESSIVE HUNGER | HYPOGLYCEMIA | OTHER: |
| NEUROLOGICAL: | CHANGE IN SLEEP | BRAIN FOG | SEIZURES-TREMORS | LOSS OF COORDINATION | FOCUS |
|  | ANXIETY | DEPRESSION | MEMORY CHANGES | COGNITIVE IMPAIRMENT | OTHER: |
| MENS HEALTH: | LOW LIBIDO | ERECTILE ISSUES | LOSS OF STRENGTH | TESTICLE CONCERNS |  |
|  | APATHY/BOREDOM | SWELLING | ACHES/PAIN | PROSTATE/URINARY | OTHER: |
| WOMENS HEALTH: | FIRST MENSES AGE \* | PERIOD CRAMPS | PELVIC PAIN | DIFFICULTY CONCEIVING | NIGHT SWEATS |
|  | CYCLE LENGTH (28d?)  \* | SPOTTING | CRAMPING | VAGINAL DISCHARGE | HOT FLASHES |
|  | PERIOD LENGTH \* | MENSES CHANGE | BIRTH CONTROL? | PMS | OTHER: |
| HEAD/EAR: | FREQUENT COLDS | DIZZINESS | HEAD TRAUMA | CHANGES IN HEARING |  |
|  | MENTAL FOG | HEADACHES | RINGING IN EARS | SINUS CONGESTION | OTHER: |
| EYES: | VISION CHANGES | DOUBLE VISION | EYE PAIN | BLURING OF VISION |  |
|  | EXCESSIVE TEARS | BLIND SPOTS | CORRECTIVE LENSES |  | OTHER: |
| NOSE/MOUTH: | CONGESTION | BLEED OFTEN | BLEEDING GUMSN | COLD/CANCRE SORES | TOOTH PAIN |
|  | NASAL DISCHARGE | NOSE OBSTRUCTION | USE OF DENTURES | BAD BREATH | OTHER: |
| NECK/THROAT: | SORE THROAT | NECK PAIN | LUMPS/BUMPS | DIFFICULTY SWALLOWING | SWOLLEN LYMPH NODES |
|  | NECK STIFFNESS | NECK TENDERNESS | POST-NASAL DRIP | PHLEGM | OTHER: |
| CHEST/LUNG: | COUGH | ASTHMA | SPITTING UP BLOOD | PAIN WITH BREATING |  |
|  | WHEEZING | SHORT OF BREATH | MANY INFECTIONS |  | OTHER: |
| CARDIOVASCULAR: | CHEST PAIN | HIGH CHOLESTEROL | LEG SWELLING | HIGH BLOOD PRESSURE |  |
|  | LIGHTHEADEDNESS | IRREGULAR BEAT | COLD HANDS/FEET | ANEMIA | OTHER: |
| URINATION: | FREQUENCY | URGENCY | MANY INFECTIONS | INCOMPLETE EMPTYING |  |
|  | PAIN | INCONTINENCE | DRIBBLING |  | OTHER: |
| MUSCULOSKELETAL: | MUSCLE CRAMPS | MUSCLE SORENESS | MUSCLE TENSION | NUMBNESS/TINGLING |  |
|  | MUSCLES WEAK | JOINT PAIN | LIMITED MOBILITY | SHAKINESS/TREMBLING | OTHER: |
| SKIN/HAIR: | THINNING HAIR | EASY BRUISING | RASH/HIVES | TEXTURE CHANGES |  |
|  | DRYNESS | ECZEMA/PSORIASIS | COLOR CHANGES | CHANGES IN NAILS | OTHER: |



**Please INITIAL and SIGN to indicate that you have read**

**and understand each statement below**.

Packet available at <http://www.nawellness.com/about-page/patient-resources/new-patient-paperwork/>

***Informed Consent for Treatment* Initial\_\_\_\_\_\_\_\_\_\_**

I have fully read, or have had read to me, the CONSENT FOR TREATMENT section of the Informed Consent Packet and I fully understand the agreements and authorizations. I voluntarily consent to services rendered by the Doctors realizing that no guarantees have been given to me. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

If Pregnant, name of OB/GYN and next appointment date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Financial Policies Acknowledgement* Initial\_\_\_\_\_\_\_\_\_\_**

I acknowledge that I have read or have had read to me the FINANCIAL POLICIES for the Clinic and agree to the to these policies and will comply with them in all respects. *I understand the cancellation policy and that full payment is due at the time of service for all fees*.

***Notice of Privacy Practices* Initial\_\_\_\_\_\_\_\_\_\_**

I acknowledge that I have read, or have had read to me, the NOTICE OF OUR PRIVACY PRACTICES section of the Informed Consent Packet and I fully understand and agree to the stipulations therein. I have been offered a copy of these policies and, if accepted, received a copy.

***Consent to communicate via email* Initial\_\_\_\_\_\_\_\_\_\_**

I acknowledge that I have read, or have had read to me, and agree to the CONSENT TO COMMUNICATE VIA EMAIL in the Informed Consent Packet.

***Consent for Intravenous Therapy* Initial\_\_\_\_\_\_\_\_\_\_**

I acknowledge that I have read, or have had read to me, and agree to the INFORMED CONSENT FOR INTRAVENOUS (IV) THERAPY in the Informed Consent Packet and that I agree with all stipulations therein.

By my signature, I affirm that I agree to all aspects of the initialed sections above, and their relevant sections in the Informed Consent Packet.

|  |  |  |
| --- | --- | --- |
| Patient (or guardian) Signature |  | Date |
|  |  |  |
| Patient (or guardian) Name (PRINT) |  | Guardian Relationship to Patient |

**CREDIT CARD INFORMATION CARD**

In many cases, patients would like to order supplies, pay for remote visits using a card that we keep on file. Please fill out the below, for your later convenience.

TYPE: VISA MASTERCARD DISCOVER

CARD NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXP. DATE: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ SEC. CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BILLING ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARD HOLDER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Naturopathic Wellness Center to take my verbal authorization as my signature for all future credit card charges