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* [x] *. If Mac, we’ll do the* [x]  *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