NAME: ______________________________

TODAY'S DATE: ________________________

DATE OF BIRTH: ________________________

AGE: _________________________________

GENDER: _____________________________

SEX ASSIGNED AT BIRTH: _________________

PREFERRED PRONOUNS: _________________

LAST PHYSICIAN SEEN: ___________________

FOR WHAT?: ___________________________

WHAT BRINGS YOU IN TODAY? ____

◻ PRIMARY MANAGEMENT	◻ ADJUNCTIVE CARE
◻ ONGOING MANAGEMENT	◻ ONE TIME ADVICE
◻ UNSURE AT THIS TIME	

HAVE YOU EVER SEEN A NATUROPATH BEFORE? _________________________________

IN GENERAL, WOULD YOU SAY YOUR HEALTH TODAY IS:

◻ EXCELLENT	◻ VERY GOOD	◻ GOOD	◻ FAIR	◻ POOR

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, FOODS, OR ENVIRONMENTAL EXPOSURES? PLEASE LIST AND EXPLAIN ALLERGIC REACTION.

ALLERGY	REACTION

PLEASE LIST DATES AND RESULTS FOR YOUR LAST:

BONE DENSITY SCAN: ____

COLONSCOPY: ____

MAMMOGRAM: ____

PAP SMEAR: ____

PROSTATE EXAM: ____

TDaP VACCINE: ____

FLU VACCINE: ____

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING. INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS, VITAMINS, MINERALS, HERBS, HOMEOPATHICS, AND PROBIOTICS.

MEDICATION	DOSE	DIRECTIONS

SOCIAL HISTORY

DO YOU FEEL SAFE IN YOUR HOME? ____________

DO YOU HAVE STABLE HOUSING? ______________

CHILDREN, AGES: _____________________________

OCCUPATION: _________________________________

CAFFEINE INTAKE: ____________________________

TOBACCO USE, TYPE: __________________________

DO YOU HAVE ENOUGH FOOD? ____________

RELATIONSHIP STATUS:___________________

TYPE OF EXERCISE, FREQUENCY: ___________

____

ALCOHOL INTAKE WEEKLY: ________________

RECREATIONAL DRUGS: __________________

MEDICAL HISTORY: PLEASE INDICATE IF YOU HAVE EXPERIENCED IN THE PAST (P) OR ARE EXPERIENCING CURRENTLY (C)

□ NO KNOWN MEDICAL ISSUES	□ ABDOMINAL PAIN	□ABNORMAL EKG
□ ADDICTION	□ ALLERGIES	□ ANEMIA
□ ANXIETY	□ APPETITE CHANGE	□ ASTHMA/COPD
□ AUTOIMMUNITY	□ ATRIAL FIBRILLATION	□ BLEEDING ISSUE
□ BLOOD CLOT	□ BLOODY STOOLS	□ BREAST LUMP
□ CANCER	□ CHEST PAIN	□ CONSTIPATION
□ COUGH	□ DEPRESSION	□ DIABETES
□ DIARRHEA	□ DIFFICULT LACTATION	□ DIZZINESS
□ ECZEMA	□ EAR INFECTIONS	□ FAINTING
□ FATIGUE	□ FEVER/CHILLS	□ FREQUENT COLDS
□ GAS/BLOATING	□ GASTRIC REFLUX	□ GENETIC DISORDER
□ HEADACHES	□ HEARING CHANGES	□ HEART MURMUR
□ HEPATITIS	□ HERPES SIMPLEX	□ HIGH CHOLESTEROL
□ HYPERTENSION	□ INFERTILITY	□ INSOMNIA
□ JOINT PAIN	□ MENSTRUAL ISSUES	□ MUSCLE PAIN
□ NIGHT SWEATS	□ NOSE BLEEDS	□ NUMBNESS
□ PALPITATIONS	□ POOR MEMORY	□ SINUS ISSUES
□ SKIN CANCER	□ SLEEP APNEA	□ STI/STD
□ SWOLLEN NODES	□ THYROID DISORDER	□ TIA/STROKE
□ TINNITUS	□ TRAUMA	□ ULCER
□ UTI	□ URINARY CHANGES	□ VISION CHANGES

□ WEIGHT CHANGE (EXPLAIN):

□ OTHER DIAGNOSES:

SURGICAL HISTORY: PLEASE INDICATE YEAR WHEN APPLICABLE

- ☐ NO PRIOR SURGERY
- ☐ APPENDECTOMY
- ☐ BLADDER SURGERY
- ☐ BREAST SURGERY
- ☐ CESAREAN SECTION
- ☐ COLON RESECTION
- ☐ GALLBLADDER REMOVAL
- ☐ HEMORRHOID SURGERY
- ☐ HERNIA REDUCTION
- ☐ HYSTERECTOMY
- ☐ TONSILLECTOMY
- ☐ TUBAL LIGATION
- ☐ VASECTOMY
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____

SEXUAL/REPRODUCTIVE HISTORY: PLEASE ANSWER QUESTIONS APPROPRIATE TO YOUR BODY AND HISTORY.

LAST MENSTRUAL PERIOD: _________________

AVERAGE BLEED LENGTH: __________________

TYPICAL CYCLE LENGTH: ____________________

NUMBER OF PREGNANCIES: _________________

CONTRACEPTION USED: ____________________

DO YOU HAVE UNPROTECTED SEX? ___________

ARE YOU SEXUALLY ACTIVE: _________________

ARE YOU MONOGAMOUS: __________________

LAST STI/STD TEST: _________________________

GENDER OF PARTNER(S): ___________________

NUMBER OF PARTNERS PAST YEAR: ___________

TYPES OF SEX: ORAL / ANAL / VAGINAL / TOYS

HAVE YOU EXPERIENCED PHYSICAL OR EMOTIONAL VIOLENCE IN YOUR RELATIONSHIP(S)? ____________

DO YOU HAVE ANY CONCERNS ABOUT YOUR FERTILITY? ____

CONCERNS ABOUT SEXUAL FUNCTION? ____

ANY OTHER SEXUAL OR REPRODUCTIVE HEALTH CONCERNS TODAY? _______________________________

FAMILY HISTORY: PLEASE INDICATE WHICH FAMILY MEMBER AND AT WHAT AGE THEY WERE DIAGNOSED.

□ ADOPTED, FAMILY HISTORY UNKNOWN:
____

□ ADDICTION:
____

□ ALLERGIES:
____

□ ASTHMA/COPD:
____

□ AUTOIMMUNE DISEASE:
____

□ BLEEDING PROBLEMS:
____

□ CANCER (TYPE):
____

□ DIABETES:
____

□ THYROID DISEASE:
____

□ GENETIC DISORDERS:
____

□ HEART DISEASE:
____

□ HIGH BLOOD PRESSURE:
____

□ HIGH CHOLESTEROL:
____

□ INFERTILITY/DIFFICULT CONCEPTION:
____

□ LACTATION PROBLEMS:
____

□ MENTAL HEALTH DIAGNOSES:
____

□ STROKE/TIA:
____

□ OTHER:
____

CARE TEAM: PLEASE LIST OTHER HEALTH CARE PROVIDERS YOU SEEK CARE FROM. INCLUDE MEDICAL DOCTORS, ACUPUNCTURISTS, CHIROPRACTORS, MASSAGE THERAPISTS, AND ANY OTHER HOLISTIC PROVIDERS.

____

____

____

AVERAGE/TYPICAL DAILY DIET: PLEASE FILL THIS OUT AS BEST YOU CAN.

BREAKFAST	
LUNCH	
DINNER	
SNACKS	
DESSERT	
BEVERAGES	
WATER	