



Natural Health Center, LLC

compassionate care changing lives

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Today's Date _____

Patient's Name _____ Age _____ Birth Date & Place _____

Occupation _____ Marital Status: Single Mar. Div. Wid. Sep. Domestic Partner

What is your major complaint? _____

Now	Past	GENERAL SYMPTOMS
_____	_____	tired, weak, lack of energy
_____	_____	frequent colds or other illnesses
_____	_____	worry, anxiety, nervousness, irritability
_____	_____	headaches
_____	_____	don't sweat enough
_____	_____	sweat too much
_____	_____	dizziness, fainting, convulsions
_____	_____	tend to be chilly
_____	_____	tend to be warm
_____	_____	sleep problems: (sleep too much, can not get to sleep, wake during the night, restless)
_____	_____	drug allergies (known or suspected)
_____	_____	list: _____

Now	Past	SKIN AND HAIR
_____	_____	acne or pimples
_____	_____	skin rashes, eruptions, boils, eczema
_____	_____	hives, itching
_____	_____	stretch marks
_____	_____	skin ulcers or sores
_____	_____	dryness, roughness, or scaling skin, scalp, knees, feet, around nose, ears, etc.
_____	_____	hair loss or thinning, change in color
_____	_____	dry, coarse hair or split ends
_____	_____	bruise easily
_____	_____	nails weak, ridged or split easily
_____	_____	brown spots or bronzing on skin
_____	_____	moles, warts or skin tags
_____	_____	sunburn easily
_____	_____	hands or feet numb or tingling
_____	_____	athlete's foot
_____	_____	other _____

Now	Past	MUSCULO-SKELETAL
_____	_____	muscle pain or stiffness. Where? _____
_____	_____	swollen, painful or stiff joints
_____	_____	fractures / frequent dislocations
_____	_____	bone pains
_____	_____	painful feet, ankles or calves
_____	_____	tremors or twitches, cramps
_____	_____	loss of strength / muscle wasting
_____	_____	other _____

Date of last bone density scan (DEXA) _____

Was it: Normal Abnormal

Now	Past	EYES
_____	_____	nearsightedness or farsightedness
_____	_____	blurred or failing vision, double vision, spots before eyes
_____	_____	dry, burning or itching eyes
_____	_____	eyes water excessively
_____	_____	eyes sensitive to light
_____	_____	night blindness
_____	_____	bloodshot hot or puffy eyes
_____	_____	other _____

Date of last eye exam: _____

Now	Past	EARS
_____	_____	earaches, ear infections
_____	_____	noises or ringing in ears
_____	_____	ear discharges
_____	_____	loss of hearing
_____	_____	lots of wax
_____	_____	other _____

Now	Past	NOSE AND THROAT
_____	_____	hay fever, sinusitis, runny nose
_____	_____	dry mouth or nose
_____	_____	nose bleeds
_____	_____	cracks in corners of mouth
_____	_____	dry or chapped lips
_____	_____	sore throat or tonsillitis
_____	_____	canker sores
_____	_____	sore, red or cracked tongue
_____	_____	cold sores or herpes
_____	_____	inability to smell or taste
_____	_____	lots of cavities, toothaches
_____	_____	bleeding gums, gum infections
_____	_____	hoarseness
_____	_____	allergies
_____	_____	chronic congestion, post nasal drip
_____	_____	other _____

Date of last dental exam _____

Now	Past	RESPIRATORY
-----	-----	cough frequently
-----	-----	spitting up mucus or blood
-----	-----	wheezing
-----	-----	shortness of breath on exertion
-----	-----	chest pain
-----	-----	pneumonia / bronchitis / pleurisy
-----	-----	difficulty breathing: at rest, after exercise, lying down, at night, triggered by emotion
-----	-----	exposure to toxic fumes, dust, chemicals or other substances
-----	-----	smoker
-----	-----	other _____
-----	-----	Date of last TB exam _____/_____/_____
-----	-----	Date of last chest x-ray _____/_____/_____

Now	Past	GASTROINTESTINAL
-----	-----	increased appetite or thirst
-----	-----	loss of appetite or thirst
-----	-----	difficulty swallowing
-----	-----	nausea or vomiting
-----	-----	bad breath
-----	-----	metallic or bitter taste in mouth
-----	-----	can not eat fats or greasy foods
-----	-----	jaundice
-----	-----	heartburn
-----	-----	indigestion or distress
-----	-----	use of antacids
-----	-----	heaviness after eating
-----	-----	gas or belching
-----	-----	bloating
-----	-----	stomach or abdomen tender or painful
-----	-----	symptoms relieved by eating
-----	-----	headache, dizziness or irritability if skip meals
-----	-----	anorexia
-----	-----	bulimia
-----	-----	diarrhea or loose stool
-----	-----	constipation
-----	-----	alternating constipation / diarrhea
-----	-----	change in bowel movements
-----	-----	light colored or greasy stools
-----	-----	dark stools
-----	-----	blood in stool, mucus in stool
-----	-----	feeling of incomplete evacuation
-----	-----	undigested food in stool
-----	-----	foul odor of stool or gas
-----	-----	hemorrhoids
-----	-----	anal itching, bleeding
-----	-----	use of laxatives
-----	-----	other _____
-----	-----	How often do you have a bowel movement? _____

Now	Past	BLOOD / LYMPH
-----	-----	excessive bleeding
-----	-----	tendency to anemia
-----	-----	history of iron supplements
-----	-----	blood disorder
-----	-----	swollen glands
-----	-----	pain or heat in lymph nodes
-----	-----	other _____

Now	Past	CARDIOVASCULAR
-----	-----	heart beats fast or irregularly
-----	-----	tightness in chest, full heavy feeling in chest
-----	-----	discomfort at high altitude
-----	-----	dizzy or weak when standing up
-----	-----	swollen feet, ankles or legs
-----	-----	cold hands or feet
-----	-----	hand or feet turn blue
-----	-----	blue fingernails
-----	-----	leg pains when walking
-----	-----	varicose veins, phlebitis
-----	-----	heart murmur
-----	-----	high blood pressure
-----	-----	low blood pressure
-----	-----	loss of hair on legs
-----	-----	toe or leg ulcers
-----	-----	heart attack
-----	-----	other _____

Now	Past	URINARY
-----	-----	difficulty urinating
-----	-----	urinate frequently at night
-----	-----	bedwetting
-----	-----	incomplete urination or dribbling
-----	-----	narrowing of stream
-----	-----	hard to start stream
-----	-----	change in color, odor, frequency of urine
-----	-----	incontinence (uncontrolled urination)
-----	-----	pain when urinating, burning
-----	-----	bladder infections
-----	-----	kidney infections, disease
-----	-----	kidney stones
-----	-----	lower back pain
-----	-----	history of IVP (kidney x-rays)
-----	-----	other _____

Now	Past	NEUROLOGICAL/PSYCHOLOGICAL
-----	-----	dizziness
-----	-----	fainting, blackouts
-----	-----	seizures or convulsions
-----	-----	tingling, numbness
-----	-----	problems walking
-----	-----	lack of coordination
-----	-----	speech problems
-----	-----	preoccupations
-----	-----	impulsive
-----	-----	shy
-----	-----	nervous breakdown
-----	-----	indecision
-----	-----	paranoia
-----	-----	thoughts of suicide
-----	-----	confusion
-----	-----	depression, anxiety, mood swings
-----	-----	irritability, cry easily
-----	-----	history of counseling, psychiatric help
-----	-----	use of psychoactive medications
-----	-----	type(s): _____
-----	-----	fears (of what): _____
-----	-----	_____

	Never	Rarely	Occasionally	Weekly	Daily (and amount)
Coffee					
Black Tea					
Alcohol					
Tobacco Chew/Smoke					
Laxatives					
Aspirin					
Soft Drinks (pop)					
Chocolate					
Other drugs					

DIET

Number of meals a day _____
 Number of snacks a day _____
 Number of glasses of water a day _____

Do you eat a special diet?

List five foods most frequently eaten:

Do you have cravings or strong desires for certain foods? (for what)

Do you avoid certain foods? (what and why)

Any allergies or adverse reactions to foods:

Do you include these in your diet? What portion (at moderate frequency)

Fast foods	Y	N	_____	Processed foods (white flour, sugar, etc.)	Y	N	_____
Fried foods	Y	N	_____	Natural, whole foods	Y	N	_____

Vitamins (please list below) Include therapeutic intent

Herbs or food supplements (please list below) Include therapeutic intent

EXERCISE

Do you get regular exercise? _____
 What type? _____
 How often? _____

Over-the-counter medications (please list below)

Prescription medications (please list below)

History of antibiotic use: _____ more than twice a year
 _____ less than once a year

Date of last use: _____/_____/_____

Have you or any of your family members had any of the problems in this chart?

Please indicate who's had which by checking the appropriate space.

Condition	Self	Mother	Father	Brothers	Sisters	Grandparents	Children	Others
Alcoholism								
Allergies								
Anemia								
Anorexia/Bulimia								
Arthritis								
Asthma								
Birth Defects								
Bleeding Disorder								
Cancer/Leukemia								
Depression								
Diabetes								
Drug Abuse								
Emphysema								
Epilepsy or Seizures								
Gallbladder Disease								
Glaucoma/Cataracts								
Gout								
Heart Attack								
Heart Disease-circulatory problems								
Hepatitis or Liver Disease								
High Blood Pressure								
Hypoglycemia								
Kidney or Bladder Disease								
Kidney Stones								
Malaria								
Mental Illness								
Migraine Headaches								
Mononucleosis								
Multiple Sclerosis								
Muscular Dystrophy								
Obesity								
Osteoporosis								
Physical Abuse								
Rheumatic Fever								
Sexual Abuse								
Scoliosis (curvature of the spine)								
Stroke								
Suicide								
Thyroid Problems, Goiter								
Tuberculosis (TB)								
Ulcers								
Sexually Transmitted Diseases								
Other:								

Thank you for taking the time to fill out this questionnaire.