NATUROPATHIC SPECIALISTS. LLC

INITIAL HISTORY/PRECONSULT FORM (5 pages)

Patient Name (on each page): ______________________________ **DOB:** ____________

List, in order of importance, your goals for working with your physician at Naturopathic Specialists:

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________

Who is your primary care physician?: ______________________________

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
CANCER TYPE (if had):						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________

Please Note When & Why You Have Had Each of the Following:

X-Rays: ______________________________
Ultrasounds: ______________________________
TB Test: ______________________________
HIV: ______________________________
Last Eye Exam: ______________________________
MRI/Cat Scans: ______________________________
Accidents: ______________________________
HCV: ______________________________
Last Dental Visit: ______________________________

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles:	D I N	**Chicken Pox**:	D I N	**Mumps**:	D I N	**Rubella**:	D I N
Tetanus:	D I N	**Whooping Cough**:	D I N	**Hemophilus (Hib)**:	D I N	**Hepatits B**:	D I N
German Measles:	D I N	**Any vaccination reactions:** ______________________________					

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List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: ____________

Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: ____________

Soda Pop: Y N P **Ounces per day if Yes/Past**: ____________

Alcohol: Y N P **How often & how much if Yes/Past**: ________

Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P

Recreational Drugs: Y N P **Any Drug Addictions**: Y N P

Any Drug Treatment: Y N P

DO YOU HAVE ANY DRUG OR OTHER ALLERGIES? IF SO PLEASE LIST THEM. IF NOT PLEASE WRITE "NONE"

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____

____

Review of Systems:

Present Weight: ___________**Weight one month ago**:__________**Weight one year ago**:______________ **Height**: __________

Maximum weight and when: __________ **Minimum weight as adult & when**: ______________________

Ideal Weight: ____________________

REGARDING THE NEXT LONG SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Do you have Good Energy? Y N P

Are you fatigued? Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? ______________________________

If you have fatigue, can you do what you need to during the day? Y N

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer of the skin:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P
NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P

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EYES				
Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision	Y N P		**Cataracts:**	Y N P
Glaucoma:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under Eyelid:**	Y N P
MOUTH/THROAT				
Canker sores:	Y N P		**Cold sores:**	Y N P
Sore Throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P
NECK				
Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P
RESPIRATORY				
Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P
CARDIOVASCULAR				
High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest Pain:**	Y N P
URINARY TRACT				
Incontinence:	Y N P		**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P		**Kidney Stones**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P
GASTROINTESTINAL				
Heartburn:	Y N P		**Bowel Movement Freq:**	
Indigestion:	Y N P		**Recent BM Change:**	Y N P
Bloating:	Y N P		**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P		**Hemorrhoids:**	Y N P
Vomiting:	Y N P		**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P		**Liver Disease:**	Y N P
Pancreatitis:	Y N P		**Ulcer**	Y N P

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MALE GENITALIA				
Testicular pain/swelling:	Y N P		**Sexually Active:**	Y N P
Hernia:	Y N P		**S.T.D.:**	Y N P
Discharge:	Y N P		**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P		**Sexual Orientation:**	Hetero Homo Bi

FEMALE GENITALIA				
Age Period Began:			**How Often Period Occurs:**	
How long period lasts:			**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P		**Menstrual Pain:**	Y N P
PMS:	Y N P		**Food cravings:**	Y N P
Times Pregnant:			**How many births:**	
Miscarriages:			**Abortions:**	
Last Pap Smear:			**Diagnosis:**	
Any abnormal paps:	Y N P		**When was abnormal:**	
Menopausal since what age:			**Use of hormones:**	Y N P
Type of hormones used:			**Healthy libido:**	Y N P
Dry vagina:	Y N P		**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P		**Vaginitis:**	Y N P
S.T.D.:	Y N P		**Mammography:**	Y N P
Sexual orientation (circle)	Hetero Homo Bi		**If Yes, what were results:**	

Please list any birth control used and ages used: ____

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MUSCULOSKELETAL				
Weakness:	Y N P		**Arthritis:**	Y N P
Stiffness:	Y N P		**Leg Cramps:**	Y N P
Tremors:	Y N P		**Pain:**	Y N P

NERVOUS				
Paralysis:	Y N P		**Sciatica:**	Y N P
Tingling/numbness:	Y N P		**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P		**Fainting:**	Y N P

MENTAL/EMOTIONAL				
Depression:	Y N P		**Anger/irritability:**	Y N P
Suicidal:	Y N P		**High-strung/tense:**	Y N P
Anxiety:	Y N P		**Fear/Panic**	Y N P
Eating disorder:	Y N P		**Psych Hospitalization:**	Y N P

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Exercise

How often do you exercise? ____________ **What type of exercise?** ______________________

For how long? ________________ **Hobbies:** ______________________________

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Sleep

How long per night? ____________ **If you wake up frequently, what is the reason?** ________________

Nightmares: Y N P **Wake Refreshed:** Y N P **Must nap during the day:** Y N P

Sleep walk: Y N P **Grind teeth:** Y N P **Snore:** Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ______________________________

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? ________

____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? ______________________________

Are you particularly sensitive to perfumes, gasoline or other vapors? ______________________

Do you use pesticides, herbicides or other chemicals around your home? ______________________

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*****if you answered "yes" to more than one question above please fill out the Environmental History Questionairre*****

Social Life

Enjoy job: Y N P **Hours worked per week:** ________ **Highest Level of Education:** ____________

Active spiritual practice: Y N P **Quality of significant relationship:** ______________________

History of sexual, mental/emotional, physical abuse: Y N P **If so, at what age and by whom:** ____________

What is your greatest health concern: ______________________________

How does it limit you the most: ______________________________

How committed are you towards making valuable changes: Little Moderately Very

Typical Day's Diet

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

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