Name _____ Age___ Birth Date_____❑ F ❑ M Blood Type _____
# of Children _____ Names & Ages_____

List Your Current Health Problems
Prioritize by listing the problems in order of importance.
1. _____ 3. _____
2. _____ 4. _____
Complete the following section for your top 3 problems (Check the bold descriptors that apply):

Problem #1: _____ Date of Onset: _____
Describe: _____
_____
Cause: _____❑ **Constant? or ❑ Intermittent?**
❑ **Worsening** or ❑ **Improving**? Why? _____
_____
Rx / Surgery / Treatments tried & the results: _____
_____
Associated personal and/or family history: _____
_____
How do you think that this problem has developed in your life?_____
_____
Office Use Only _____
_____
_____

Problem #2: _____ Date of Onset: _____
Describe: _____
_____
Cause: _____❑ **Constant? or ❑ Intermittent?**
❑ **Worsening** or ❑ **Improving**? Why? _____
_____
Rx / Surgery / Treatments tried & the results: _____
_____
Associated personal and/or family history: _____
_____
How do you think that this problem has developed in your life?_____
_____
Office Use Only _____
_____
_____

Problem #3: _____ Date of Onset: _____

Describe: _____

_____

Cause: _____❑ **Constant? or** ❑ **Intermittent?**

❑ **Worsening** or ❑ **Improving**? Why? _____

_____

Rx / Surgery / Treatments tried & the results: _____

_____

Associated personal and/or family history: _____

_____

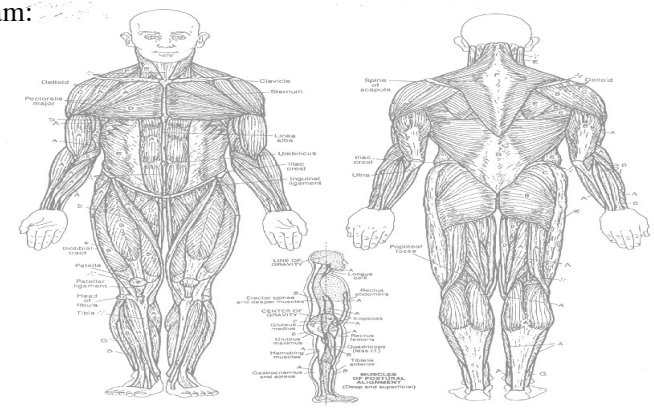
How do you think that this problem has developed in your life?_____

_____

Office Use Only _____
_____
_____

Use diagram to illustrate the areas on your body where you feel any of the following sensations:
Use the following letters to mark the diagram:

A = Numbness
B = Deep Aching
C = Burning
D = Stabbing
E = Pins & Needles
F = Throbbing
G = Itching



General Information

Have you seen a naturopathic doctor before? ❑ No ❑ Yes
Are you currently seeing one? ❑ No ❑ Yes Doctor's name: _____
Do you have a medical doctor? ❑ No ❑ Yes Doctor's name: _____
Have you seen a chiropractic doctor before? ❑ No ❑ Yes
Are you currently seeing one? ❑ No ❑ Yes Doctor's name: _____
Do you see any other healthcare professional (i.e. acupuncturist, massage therapist, counselor)? ❑No❑Yes
Explain: _____
What are the most significant measures that you have taken to improve your state of health? _____
_____
_____
Tobacco Use: ❑ No ❑ Yes Smoke/Chew: ____years – Amount Per Day: _____ Year Stopped:_____
Alcohol Use: ❑ No ❑ Yes Type: _____ rEquency: _____
Recreational Drug Use: ❑ No ❑ Yes ypE _____Frequency: _____

Did you receive COVID19 vaccine? When? Which ones? Any adverse reactions?
_____
Did you have CV19? 100% recovered from CV19 illness? If not, what symptoms do you struggle with?
_____

Your Medical History

List the prescription and non-prescription medications, vitamins, minerals, & herbs that you are currently taking:_____

_____

List any medications that have been prescribed, but you are not taking: _____

List major illnesses, hospitalizations surgeries or serious injuries (include date & brief description): _____

_____

Allergies to drugs, food, or other substances? ❑ No ❑ Yes Describe: _____

Height _____Weight _____ Weight 1 year ago _____ Max Weight _____ When?_____

Minimum Adult Weight _____When _____Blood Pressure _____Heart Rate _____

Personal | Family History (❑ Unknown)

Please check and name who was affected (Self, Mother, Father, Grandparents, Sisters, Brothers, Children)

❑ AIDS/HIV _____
❑ Alcoholism _____
❑ Allergies _____
❑ Alzheimer's/Dementia_____
❑ Anemia _____
❑ Arthritis _____
❑ Asthma _____
❑ Cancer _____
❑ Childhood trauma _____
❑ Depression _____
❑ Diabetes _____
❑ Drug Problems _____
❑ Eczema _____
❑ Gout _____
❑ Heart disease _____
❑ High blood pressure _____
❑ Hypoglycemia _____
❑ Kidney disorder _____
❑ Mental illness _____
❑ Migraines _____
❑ Obesity _____
❑ Psoriasis _____
❑ Sex abuse _____
❑ Seizures _____
❑ Stroke _____
❑ Suicide _____
❑ TB _____
❑ Thyroid problems _____
❑ Ulcer _____
❑ Other _____

Review of Systems

Please check all the problems you have currently (in the past week):

Constitutional	**Gastrointestinal**	**Integumentary/Skin**
Good general health ❑	Nausea/vomiting ❑	Abnormal nails ❑
Recent weight change ❑	Abdominal pain ❑	Rashes or itching ❑
Night sweats, fevers ❑	Rectal bleeding ❑	Breast irregularity ❑
Fatigue/weakness ❑	Indigestion/heartburn/reflux ❑	Dry/discolored Skin ❑
	Constipation/diarrhea ❑	
Ears / Nose / Mouth / Throat	**Musculoskeletal**	**Allergic / Immunologic**
Hearing loss or ringing ❑	Muscle pain or cramps ❑	Food allergies ❑
Sinus problems ❑	Stiffness/swelling joints ❑	Frequent infections ❑
Nose bleeds ❑	Joint pain ❑	Hay fever ❑
Sore throat/voice change ❑	Trouble walking ❑	Chemical Sensitivity ❑
Eyes	**Neurological**	**Genitourinary**
Wear glasses/contacts ❑	Frequent headaches ❑	Blood in urine ❑
Blurred/double vision ❑	Paralysis or tremors ❑	Pain/burning on urination ❑
Eye disease or injury ❑	Convulsions/seizures ❑	Frequent urination ❑
Eye pain/dryness ❑	Numbness/tingling ❑	Kidney stones ❑
Cardiovascular	**Hematologic / Lymphatic**	**Genitourinary – Continued**
Chest pain ❑	Anemia ❑	Sexual problems ❑
Palpitations ❑	Bruise easily ❑	Testicle/ovary pain ❑
Heart trouble ❑	Slow to heal ❑	Infertility ❑
Swelling hands/feet ❑	Enlarged glands ❑	Menstrual problems ❑
Lightheaded ❑		
Respiratory	**Endocrine**	**Psychiatric**
Shortness of breath ❑	Excessive Thirst/urination ❑	Insomnia/nightmares ❑
Cough ❑	Hair loss ❑	Confusion/memory loss ❑
Wheezing/Asthma ❑	Cold hands/feet ❑	Depression/fears/cries easily ❑
Bad breath ❑	Hormone problems ❑	Anxiety/panic attacks ❑
	Light sensitivity ❑	

1 - How did you come to be this way? What is your personal biography? (Can use another page)
2 - How can you be with your pain of mind, body and spirit in a way that is wise, compassionate and healing?