Patient Health Questionnaire

Date: _____

Name: _____

Address: _____

_____

Home Phone: _____ Cell: _____

Work: _____

E-mail: _____

Age: _____ Date of Birth: _____

Emergency Contact's Name: _____

Relationship: _____ Phone: _____

How did you hear about our clinic? _____

Personal information:

What are your most important health concerns?

_____

_____

Allergies: _____

_____

_____

_____

Current Medications: _____

_____

_____

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? Please list.

_____

_____

Are there any behaviors or lifestyle habits do you currently engage in regularly that you believe are detrimental to your well-being?

_____

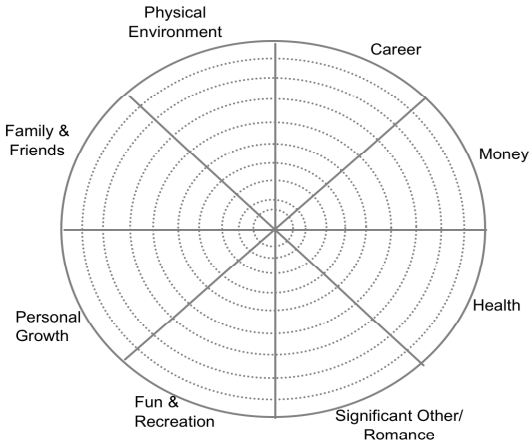
_____

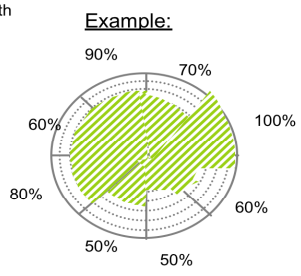
How did your health conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify having caused or clearly aggravates your health problems?

_____

_____

Please complete:





Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

Habits:

Interests and hobbies: _____

Type of exercise, times per week: _____

How many hours a night do you sleep?_____ Do you awake feeling rested? Yes No

What time of day do you feel at your best? _____ at your worst?_____

Past Medical History:

Which Immunizations have you had? Place a (?) if you do not know.

	Diphtheria/Tetanus/Pertussis		Measles/Mumps/Rubella		Influenza
	Polio		Varicella (Chicken Pox)		Hepatitis A
	Hepatitis B		Smallpox		Other:

Have you had the following childhood illness?

	Scarlet Fever		Diphtheria		Rheumatic Fever
	Mumps		Measles		Rubella (German measles)
	Asthma		Chicken Pox		Roseola
	Chronic Ear Infections		Strep throat		Other:
	Whooping Cough		Mononucleosis		Other:

Hospitalization or surgeries?

_____

_____

Recent screening tests? (List date and results)

_____

_____

General:

What do you normally eat for:

Breakfast? _____

Lunch? _____

Dinner? _____

Snacks? _____

Beverages (including water intake): _____

Favorite foods: _____ Disliked foods: _____

Weight: _____ Weight 1 year ago: _____ Maximum weight: _____ When? _____

Height: _____

Self & Family History. Circle if current or past concerns for you or your family

Arthritis	Self Current?	Father	Mother	Sister	Brother	Children	
Asthma	Self Current?	Father	Mother	Sister	Brother	Children	
Alcoholism	Self Current?	Father	Mother	Sister	Brother	Children	
Cancer	Self Current	Father	Mother	Sister	Brother	Children	Type:
Cataracts	Self Current	Father	Mother	Sister	Brother	Children	
Diabetes	Self Current	Father	Mother	Sister	Brother	Children	Type:
Eczema	Self Current	Father	Mother	Sister	Brother	Children	
Epilepsy/ Seizures	Self Current	Father	Mother	Sister	Brother	Children	
Gallbladder Disease	Self Current	Father	Mother	Sister	Brother	Children	
Glaucoma	Self Current	Father	Mother	Sister	Brother	Children	
Gout	Self Current	Father	Mother	Sister	Brother	Children	
Hay Fever/Hives	Self Current	Father	Mother	Sister	Brother	Children	
Heart Disease	Self Current	Father	Mother	Sister	Brother	Children	
Heart Murmur	Self Current	Father	Mother	Sister	Brother	Children	
High Blood pressure	Self Current	Father	Mother	Sister	Brother	Children	
Kidney Disease	Self Current	Father	Mother	Sister	Brother	Children	
Liver Disease	Self Current	Father	Mother	Sister	Brother	Children	
Mental Illness	Self Current	Father	Mother	Sister	Brother	Children	Type:
Stroke	Self Current	Father	Mother	Sister	Brother	Children	
Thyroid disorders	Self Current	Father	Mother	Sister	Brother	Children	
Tuberculosis	Self Current	Father	Mother	Sister	Brother	Children	

Simple
Family Health

REVIEW OF SYSTEMS

Please mark the following boxes: C=Current issue, H=Past Issue, Leave blank for never an issue

SKIN

- Rashes
- Eczema, hives
- Acne, boils
- Itching
- Lumps
- Night Sweats
- Loss of hair
- Color change

HEAD

- Frequent headaches
- Head Injury
- Jaw/TMJ pain
- Migraines/intense headaches

EARS

- Impaired hearing
- Ringing
- Earache
- Dizziness

EYES

- Impaired vision
- Glasses/contacts
- Eye pain
- Tearing or dryness
- Double vision
- Glaucoma
- Spots in the eyes
- Cataracts

NOSE

- Frequent colds
- Nose bleeds
- Stuffiness
- Hay fever
- Sinus congestion
- Loss of smell

MOUTH & THROAT

- Frequent sore throat
- Sore tongue/lips
- Gum problems
- Hoarseness
- Dental cavities
- Copious saliva
- Difficulty swallowing
- Cold sores/blisters

NECK

- Lumps
- Swollen glands
- Goiter
- Pain or stiffness

RESPIRATORY

- Cough
- Sputum
- Spitting up blood
- Wheezing

RESPIRATORY

- Asthma
- Bronchitis
- Pneumonia
- Emphysema
- Difficulty breathing
- Shortness of breath
- Lying down
- Pain on breathing

CARDIOVASCULAR

- Chest pain walking
- Chest pain lying
- Ankle swelling
- Palpitations/flutter
- Leg vein problems
- Leg pain walking
- Angina
- Numbness / tingling in extremities

GASTROINTESTINAL

- Heartburn
- Change in appetite
- Nausea
- Abdominal pain
- Vomiting (w/ blood?)
- Blood in stool
- Black stools
- Alternating symptoms
- Belching/passing gas
- Diarrhea
- Constipation
- Hemorrhoids

URINARY

- Pain on urination
- Increase frequency
- Frequent at night
- Difficulty holding urine
- Freqaent infections
- Blood in the urine
- Kidney stones

MUSCULOSKELETAL

- Joint pain or stiffness
- Broken bones
- Muscle spasm or cramps
- Weakness

BLOOD

- Anemia
- Easy bleeding / bruising

PERIPHERAL VASCULAR

- Deep leg pain
- Cold hands/feet
- Varicose veins
- Thrombophlebitis

NEUROLOGIC

- Fainting
- Seizures
- Paralysis
- Muscle weakness

MENTAL / EMOTIONAL

- Numbness or tingling
- Loss of memory
- Tremor (shaking, trembling)
- Depression
- Mood swings
- Anxiety/nervousness
- Considered / attempted suicide

MENTAL / EMOTIONAL

- Tension
- Poor concentration
- Memory problems
- Excessive worry

IMMUNE

- Painful lymph nodes
- Chronic infections
- Slow wound healing
- Fluid retention
- Difficulty stopping bleeding
- Chronic Fatigue Syndrome
- Chronically swollen glands

Are you sexually active? Yes No With?(Circle one) men women both

Birth control method/Sexual Transmitted Illness Protection?

_____

_____

MALE ONLY

	Premature ejaculation		Painful erection		Discharge from penis
	Urination difficult/dribbling		Infertility		Impotence
	Testicular masses		Prostate problems		Testicular pain
	Hernias		Other:		

FEMALE ONLY

Age of first menses: _____ Menses occur every _____ days. Regular? _____

Menses usually last _____days.

Date of last annual exam/PAP _____Were the results normal? _____

Have you ever had an abnormal pap smear? _____ If yes, explain: _____

Number of pregnancies _____ Number of live births _____ Number of miscarriages _____

Number of abortions _____

	Bleeding between cycles		Clotting		Cervical dysplasia		PMS
	Painful menses		Discharge		Sexual difficulties		Pain during intercourse
	Excessive flow		Endometriosis		Ovarian cysts		Breast lumps
	Nipple discharge		Breast pain/ tenderness		Pelvic pain		Do you do breast self exams

NATUROPATHIC INFORMED CONSENT TO TREAT

Patient Name: _____

Consent: I herby request and consent to the performance of naturopathic treatments and / or other naturopathic procedures, including various modes of physical exams and diagnostic procedures including venipuncture and lab diagnostics, on me (or on the patient named above, for whom I am legally responsible) by the doctor of naturopathy named above and/or other licensed doctors of naturopathy who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of naturopathy named above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not.

Type of Care: I understand my right to discuss with Dr. Jennifer Strider, N.D. and/or with other clinic personnel the nature and purpose of naturopathic care and procedures. A description of the specific care which is currently contemplated includes homeopathy, botanical medicine, clinical nutrition including vitamins, minerals, amino acids, flower essences, physical medicine and bodywork, lifestyle changes and/or any other therapy that falls within the Naturopathic Doctor's license guidelines, and is agreed upon by patient and doctor.

No Guarantee: I understand that results are not guaranteed.

Recital of Risks: I understand and am informed that, as in the practice of medicine, in the practice of naturopathy, there are some risks to treatment, including, but not limited to: allergic reaction to botanical medicines, side effects of natural medications, inconvenience of lifestyle changes, venipuncture for diagnostic testing, and possible prescription drug interaction with prescribed natural supplements or products.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Potential Benefits: Restoration of health and vitality of body and mind, relief of pain and symptoms of disease, education about healthy lifestyle choices for you and your family, and possible prevention of disease or its progression.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's or Legal Guardian's Signature Date

_____

Printed Patient's Name or Legal Guardian

CONFIDENTIALITY:

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that I may request to view my medical record and can request a copy of it by paying the appropriate copying fee.

I understand that my medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.

I certify that I have read and fully understand this consent and the matters, which have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for an on behalf of the above-named patient and that I am signing freely and voluntarily.

I understand that email is not considered a secure method of communication with my doctor. If I choose to email my doctor, I understand that she may be limited in her response or may need to call or fax me a response as is obligated under the HIPAA act.

Do we have permission to leave detailed personal messages on an answering machine or voicemail?

(Please Initial: ____ Yes ____ No)

Please provide appropriate contact number(s) and sign below:

Phone: _____ (Circle: home cell office other: _____)

And/or: _____ (Circle: home cell office other: _____)

Email address: _____

Would you like to receive a copy of our newsletter or a link to our blog? Yes No

_____ _____

Patient's or Legal Guardian's Signature Date

_____

Printed Patient's Name or Legal Guardian