STANDARD INITIAL CONSULTATION FORM

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Please fill out the following as thoroughly as possible. Print clearly and mark anything you don't understand with a question mark. This questionnaire asks about your physical, mental and emotional health, all of this information will assist in providing you with the best naturopathic care possible.

(Referred form from UBCNM)

Personal Information

Today's Date_____________

Name_________________________________Age_____Date of birth_____/____/_____Sex M/F

Address_________________________________City____________ State_______Zip_________

Email address__________________________________ Social Security #____-____-_____

When did you last receive medical care?____

Where?__________________________Why?____

Doctor(s) currently seen:

Name__________________________________Practice Name___________________________

Address_______________________________ City___________ State_______Zip__________

Phone office (___)_________________ fax (___)_________________

Name__________________________________Practice Name___________________________

Address_______________________________ City___________ State_______Zip__________

Phone office (___)_________________ fax (___)_________________

Health History

Vaccinations/Immunization

Y N	Polio	Y N	Pertussis	Y N	Chickenpox
Y N	Tetanus	Y N	Diptheria	Y N	MMR (measles/mumps/rubella)
Y N	Hepatitis B	Y N	Other__________________		

Childhood Illnesses

Y N	Rubella	Y N	Measles	Y N	Roseola
Y N	Mumps	Y N	Chickenpox	Y N	Whooping cough
Y N	Polio	Y N	Eczema	Y N	Rheumatic fever
Y N	Diptheria	Y N	Asthma	Y N	Scarlet fever

Other__________________

List any known **allergies** (environmental, food, drug) and reaction:

____

____

Do you currently take any of the following medications? Check all that apply:
__Aspirin __Ibuprofen or acetaminophen __Sleeping pills __Antihistamine
__Laxatives __Appetite depressants __Antacid __Medicine to stay awake
__Cortisone __Birth control pills/patch/ring __ Antibiotics __ Hormones/thyroid med

List all medications (prescriptions), vitamins, and other supplements you are taking currently or have taken in the past year (attach additional sheet if needed):

Medication	Dosage/Frequency	Dates	Reason for taking	Who Prescribed

If any of the following apply to you, please fill in known information, add other procedures if needed:

Procedure	Reason	Date	Outcome	Procedure	Reason	Date	Outcome
Hospitalization				Hospitalization			
Surgery				Surgery			
X-Ray				MRI			
Bone scan				EKG			
Endoscopy				Echocardiogram			
Colonoscopy				EEG			
Rectal Exam				Mammogram			

Current Health History

Please check next to appropriate item(s), or circle as indicated:

Head – eyes, ears, nose, throat

now	past		now	past		now	past	
___	___	headaches	___	___	dizziness	___	___	runny nose
___	___	blurry vision	___	___	fainting/blackouts	___	___	loss of smell
___	___	halo around objects	___	___	loss of balance	___	___	nosebleeds
___	___	eye pain/red eye	___	___	ringing in ears	___	___	neck lumps
___	___	cataracts/glaucoma	___	___	difficulty hearing	___	___	earaches
___	___	grinding teeth	___	___	cold /canker sores	___	___	sore throat
___	___	dental problems	___	___	difficulty swallowing	___	___	hoarse voice

Chest – lungs, heart

now	past		now	past		now	past	
___	___	wheezing	___	___	chest colds	___	___	palpitations
___	___	shortness of breath	___	___	unexplained fever	___	___	chest pain
___	___	cough up blood	___	___	night sweats	___	___	swollen feet
___	___	cough up phlegm	___	___	rapid/skipped beats	___	___	high blood pressure

Abdomen - stomach, liver

now	past		now	past		now	past	
___	___	indigestion	___	___	pain in abdomen	___	___	constipation
___	___	light colored stools	___	___	nausea	___	___	diarrhea
___	___	rectal pain or itch	___	___	loss of appetite	___	___	vomiting
___	___	frequent belching/gas	___	___	yellow skin/jaundice	___	___	excessive appetite

Genitourinary – reproductive organs, bladder

now	past		now	past		now	past	
___	___	frequent urination	___	___	pain with urination	___	___	blood in urine
___	___	urge to urinate	___	___	weak urine stream	___	___	kidney stones
___	___	incontinence	___	___	groin itching	___	___	genital warts
___	___	genital sores	___	___	sexual difficulty	___	___	STD/STI

Musculoskeletal and Skin – joints, bones

now	past		now	past		now	past	
___	___	sore/swollen joints	___	___	leg cramps	___	___	restless legs
___	___	aching muscles	___	___	weakness	___	___	broken bones
___	___	numbness	___	___	tingling	___		hives
___	___	rash/ itching	___	___	bruising	___	___	acne

Nervous system and Mental Emotional

now	past		now	past		now	past	
___	___	anxiety	___	___	loss of memory	___	___	nervousness
___	___	ADD/ADHD	___	___	lonely	___	___	depressed
___	___	hopelessness	___	___	frequent crying	___	___	frequent worry
___	___	difficulty relaxing	___	___	shy/sensitive	___	___	angered easily
___	___	work problems	___	___	family problems	___	___	suicidal
___	___	difficulty with decisions	___	___	scary thoughts/dreams	___	___	annoyed by little things

Men only

now	past		now	past		now	past	
___	___	painful testes	___	___	swelling in testes	___	___	discharge
___	___	impaired fertility	___	___	prostate problem	___	___	sexual abuse
___	___	self-testicular exam	___	___	sexually active	___	___	condom use

Sexual orientation: Heterosexual___ Homosexual__ Bisexual__Transgendered__

Women only

now	past		now	past		now	past	
___	___	missed period(s)	___	___	irregular bleeding	___	___	chronic yeast
___	___	frequent vaginitis	___	___	breast pain/lump	___	___	PMS
___	___	PCOS	___	___	endometriosis	___	___	sexual abuse
___	___	vaginal dryness	___	___	HRT	___	___	hot flashes
___	___	genital irritation	___	___	vaginal discharge	___	___	infertility
___	___	difficulty with exams	___	___	heavy/light menses	___	___	nipple discharge
___	___	painful intercourse	___	___	bearing down feelings	___	___	new facial hair/hair loss

Women only (cont)

___ ___ sexually active

Sexual orientation: Heterosexual___ Homosexual__ Bisexual__ Transgendered__

Number of pregnancies___ live births___ miscarriages___ abortions___

Age of first menses______ Do you perform self breast exams? Y / N Date of last pap____/___/__

Usual length of cycle (from first day of bleeding to next) period__Date of last menses___/__/___

Do you use birth control? (List all types used.)_______________________________________

List any other health issues/symptoms:

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____

____

Family History

If you or anyone in your immediate famly has or had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

Cancer (type)___________________________

Anemia________________________________

Heart Disease___________________________

Stroke_________________________________

High blood pressure_____________________

Alcoholism or substance abuse____________

Attempted suicide_______________________

Mental illness__________________________

Glaucoma______________________________

Other_________________________________

Diabetes __________________________

Arthritis__________________________

Asthma/hay fever/hives_____________

Osteoporosis______________________

Depression________________________

Autoimmune disease_______________

Kidney disease_____________________

Seizures/Epilepsy__________________

Gout_____________________________

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Social History

Are you currently in a relationship?_________Is this a satisfying relationship?_______________

With whom do you live? (list all members of household)________________________________

Does your income meet your monthly needs?____

Have you traveled outside the U.S. in the past 5 years? Where?____________________________

Do you camp?____ Where?____

Military service?______When and where?____

Social History (cont)

Alcohol use: _______ drinks/ week Tobacco use: ____packs/ day ___cigars /day ___chew/day

Recreational drug use: Y/N List all used currently:__________________Past use:____________

Do you want help to quit any of these substances?_______________________________________

Exercise_____hours/week What types?____

What are your hobbies?____

Do you take time to relax? Y/N How?______________Number of hours you watch TV_____/day

Do you have a religious/spiritual belief? Y/N Do you practice regularly?_____________________

Major life changes in the last year____

Level of stress: low__ medium__ high__ How do you handle stress?_____________________

Diet

Are you satisfied with your diet? Y/N Circle # of meals eaten per day: 1 2 3 more than 3

C**ommonly eaten** foods in your day to day diet:____

____

Foods **excluded** from diet:____

Caffeinated drinks (coffee, tea, soda)_______/day

Foods/drinks that you crave:____

Are you thirsty?____ Preferred temperature of drinks:___________________________________

Sleep

Hours/ night_____Is this enough? Y/N Do you have any problems with your sleep?_________

Any recurring dreams?____

Any position that you always sleep in? Or cannot sleep in?________________________________

Environmental Exposures

Home Environment

Circle any of the following that you are exposed to:

gas heat	oil heat	wood stove	electric heat	air conditioning
tap water	dust	mold	excessive dampness/dryness	
animal/pet hair	poor ventilation		amalgam fillings	

List any other exposures:____

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Environmental Exposures (cont)

Work Environment
Outdoor work (what type)____
Indoor work (what type)____
List chemicals/odors/dust you are exposed to at work currently or have been in the past (eg: toner ink, bark dust, floor dust, hair color…)

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Hobbies or Activities
List any chemicals/odors/dust you are exposed to from hobbies or have been in the past

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Write anything additional concerns or anything you'd like to include to help us get to know you better.

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