

Please list your previous medical diagnoses:

1. Diagnosis _____	Date of Onset: _____	Doctor Involved: _____
Current symptoms: _____	Current treatments: _____	Treatments received in the past: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
What aggravates your condition? _____	What helps your condition? _____	In your mind, what caused this problem? _____
_____	_____	_____
_____	_____	_____
What do you hope for as we work together to treat this problem naturopathically? _____		

2. Diagnosis _____	Date of Onset: _____	Doctor Involved: _____
Current symptoms: _____	Current treatments: _____	Treatments received in the past: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
What aggravates your condition? _____	What helps your condition? _____	In your mind, what caused this problem? _____
_____	_____	_____
_____	_____	_____
What do you hope for as we work together to treat this problem naturopathically? _____		

3. Diagnosis _____	Date of Onset: _____	Doctor Involved: _____
Current symptoms: _____	Current treatments: _____	Treatments received in the past: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
What aggravates your condition? _____	What helps your condition? _____	In your mind, what caused this problem? _____
_____	_____	_____
_____	_____	_____
What do you hope for as we work together to treat this problem naturopathically? _____		

4. Diagnosis _____	Date of Onset: _____	Doctor Involved: _____
Current symptoms: _____	Current treatments: _____	Treatments received in the past: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What aggravates your condition?

What helps your condition?

In your mind, what caused this problem?

What do you hope for as we work together to treat this problem naturopathically?

Please list any prescription medication you are currently taking..

Medication:

Reason:

Year Started:

Dosage:

Eg. Lipitor

High cholesterol

2000

10mg once daily

Please list any over the counter medication you are currently taking.

Medication:

Reason:

Frequency:

Dosage:

Eg. Advil

Pain relief

3 times/week

250mg twice daily

Please list any nutritional supplements, herbs, or homeopathics you are taking.

Supplement/Manufacturer/Form:

Reason:

Date Started:

Dosage:

Eg. Quercetin/Natural Factors/capsules

Allergies

May 10, 2004

235mg 3x/daily

Patient Name _____ DOB _____ Date _____

Please list any known allergies.

Drug Allergy:

Food Allergy:

Environmental Allergy:

Family Health History

Are you adopted? Yes No

Please check if you have any of the following family history:

- | | | | | |
|-------------------------------------|--|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Autoimmune dz | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other – |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteoporosis | Please list: |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke | |

	Current Age	Age of Death	Significant health problem or cause of death
Father			
Mother			
Brothers/Sisters (list)	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
Children (list)	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Please leave this space blank for doctor use

Patient Name _____ DOB _____ Date _____

Childhood Medical History

Any complications during your mother's pregnancy with you? Yes No

If so, please describe: _____

Please check the box that describes how you were born:

Vaginal C-section Forceps Vacuum Trauma?

Any newborn problems?

Jaundice Extended hospitalization Other, please describe: _____

As a baby, were you fed:

Breastmilk Formula Mixed

Do you know at what age you were first given solid foods? _____

Please describe your diet as a child: _____

Please indicate if you had any of the following childhood illnesses.

Acne Chicken pox Mono pox Pertussis Rubella Scarlet Fever
 ADD Measles Mumps Polio Rheumatic Fever Other: _____

How often did you get sick as a child? _____

What kind of illnesses did you usually experience? *Eg. Ear infections, sore throat, cough, allergies, asthma...*

How often did you take antibiotics? _____

Please list any other medications taken regularly as a child. _____

Please describe your vaccination history.

I was fully vaccinated I was selectively vaccinated I was not vaccinated

Check the vaccinations that you've had:

Chicken pox Hepatitis B MMR Polio Other: _____
 DPT HIB Pneumonia PPD _____

Last tetanus booster: _____

Do you get the flu vaccine? _____

Have you ever had an adverse reaction to a vaccine? Yes No

Please describe your childhood home environment.

As a child, what adults lived with you? _____

Your birth order? *Eg. 3 of 5 kids* _____

Was your home safe? _____

Did you have any traumas or losses as a child? _____

Did you grow up in the city, suburbs or in a rural area? _____

Any difficulties in school? _____

Did anyone in your home smoke or use drugs regularly? _____

Patient Name _____ DOB _____ Date _____

Other Lifestyle Factors

Please describe your physical activity level:

- Sedentary *Eg. No exercise*
- Mild exercise *Eg. Climb stairs, walk 3 blocks, golf*
- Occasional exercise *Eg. Work or recreation for 30 minutes duration less than 4 times weekly*
- Regular vigorous exercise *Eg. Work or recreation for 30 minutes more than 4 times weekly*

After moderate or vigorous exercise, how do you feel? Great Drained

Please list your current body weight: _____ Desired body weight: _____

What is the most _____ and least _____ that you have weighed as an adult (excluding pregnancy)?

Do you diet to lose weight? Yes No

Do you take medications, herbs, or supplements to lose weight? Yes No

Do you have, or have you ever had, an eating disorder? No Binging Purging Avoidance of food

BMI *Please leave blank for doctor use*

Please list who you currently live with. *Eg. Spouse, children, roommates, pets*

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is your home a sanctuary for you? Yes No

Does your home have lead paint? Yes No

Is your home moldy? Yes No

Is your home safe? Yes No

Is there a gun in your home? Yes No

Do you work primarily inside or outside the home?

Please list your present occupation. _____

How many hours a week do you work? _____

How many days a week do you work? _____

Do you spend more than half of your day at a desk or computer? Yes No

Do you take vacations? Yes No

Are you happy in your work? Yes No

Please check off any potential toxic exposures

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Glassblowing | <input type="checkbox"/> Painting | <input type="checkbox"/> Other mercury exposure |
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Lead paint | <input type="checkbox"/> Pesticides | <input type="checkbox"/> Other solvents |
| <input type="checkbox"/> Cleaning chemicals | <input type="checkbox"/> Mercury fillings | <input type="checkbox"/> Pottery | |
| <input type="checkbox"/> Electric power lines | <input type="checkbox"/> Model building | <input type="checkbox"/> Second-hand smoke | |
| <input type="checkbox"/> Frequent air travel | <input type="checkbox"/> Nuclear power plant | <input type="checkbox"/> Other heavy metals | |

Patient Name _____ DOB _____ Date _____

Dietary Assessment and Habits

How many servings of red meat (beef, lamb, pork, etc.) do you eat each week?

How many servings of fish do you eat each week?

How many servings of poultry (chicken, turkey, duck, etc) do you eat each week?

How many servings of beans do you eat each week?

How many servings of soy (tofu, soy milk, tempeh, etc) do you eat each week?

How many servings of dairy products (milk, ice cream, yogurt, etc) do you eat each week?

How many servings of fruit do you eat each day? *Eg. 1 serving = 1 small piece of fruit, ½ cup juice, ¼ cup dried fruit*

How many servings of vegetables do you eat each day? *Eg. 1 serving = ½ cup raw or cooked vegetables, 1 cup fresh green leafy vegetables*

How many sweets or desserts do you eat each day? What types?

How many times do you eat out each week?

How many times to you eat 'fast food' each week?

How many glasses of water do you drink each day?

How many glasses of other drinks do you have each day? What types?

Please list any foods that you crave.

Patient Name _____ DOB _____ Date _____

Recall of Dietary Intake

Please list all foods and drinks you have consumed in the previous 48 hours. Include meals, snacks, beverages and condiments.

Breakfast

	Food Item	Preparation <i>Eg. Baked, fried</i>	Amount
Day 1			
Day 2			

Lunch

	Food Item	Preparation <i>Eg. Baked, fried</i>	Amount
Day 1			
Day 2			

Dinner

	Food Item	Preparation <i>Eg. Baked, fried</i>	Amount
Day 1			
Day 2			

Patient Name _____ DOB _____ Date _____

Snacks

	Food Item	Preparation <i>Eg. Baked, fried</i>	Amount
Day 1			
Day 2			

Alcohol Intake

Do you drink alcohol? Yes No What kind? _____ How many drinks/week? ____

Do you feel you drink too much? Yes No Have you ever experienced blackouts? Yes No

Are you prone to binge drinking? Yes No Do you feel guilty about your drinking? Yes No

Do you drive after drinking? Yes No Are you sensitive to criticism of your drinking?
 Yes No

Tobacco

Do you currently, or have you in the past, used tobacco? Yes No

Please check the box that applies to you.

Cigarettes Chew Pipe Cigars

___ packs/day ___ times/day ___ times/day ___ times/day

For how many years have you used tobacco products? _____

In what year did you quit using tobacco products? _____

Drug Use

Do you currently use recreational or street drugs? Yes No

Have you ever given yourself street drugs with a needle? Yes No

Caffeine

Do you drink coffee? Yes No Amount: _____

Do you drink soda? Yes No Amount: _____

Do you drink caffeinated tea? Yes No Amount: _____

Other: _____ Amount: _____

Patient Name _____ DOB _____ Date _____

Elimination

Gut

How often do you have a bowel movement? _____

Does your stool have any of the following qualities?

- | | | | | |
|---|---------------------------------|---------------------------------|--------------------------------|---------------------------------|
| <input type="checkbox"/> Undigested food | <input type="checkbox"/> Formed | <input type="checkbox"/> Dry | <input type="checkbox"/> Tan | <input type="checkbox"/> Yellow |
| <input type="checkbox"/> Bright red blood | <input type="checkbox"/> Loose | <input type="checkbox"/> Greasy | <input type="checkbox"/> Black | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Mucus | <input type="checkbox"/> Hard | <input type="checkbox"/> Brown | <input type="checkbox"/> Green | |

Do you strain to pass stool? Yes No Do you experience gas bloating, belching? Yes No

Do you have hemorrhoids? Yes No Do you even unintentionally pass stool? Yes No

Please check any box that applies to you.

- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Recent change in bowel habits |
| <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Constipation | <input type="checkbox"/> None | |

Kidneys

How often do you urinate? _____

Please check any box that applies to you.

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Must get up at night to urinate | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Urinate too frequently | <input type="checkbox"/> Leaking urine when coughing or laughing | <input type="checkbox"/> Recurrent urinary tract infection |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Leaking urine at other times | <input type="checkbox"/> Other |
| <input type="checkbox"/> Urinary flow obstruction | | <input type="checkbox"/> None |
| <input type="checkbox"/> Dribbling at end of urination | | |

Skin

Do you sweat easily? Yes No

Do you use antiperspirant? Yes No

Do you apply lotions or oils to you skin? Yes No

Do you scrub or dry brush your skin? Yes No

What type? _____

Please note if you have any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Pigment changes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Contact dermatitis | <input type="checkbox"/> Hair loss or unusual growth | <input type="checkbox"/> None |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Moles | <input type="checkbox"/> Yellowing of the skin | |
| <input type="checkbox"/> Chronic itching | <input type="checkbox"/> Hives | | |

Liver

Please note if you have any of the following.

- | | | | |
|--|--|---|-------------------------------|
| <input type="checkbox"/> Yellowing of the skin | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> PMS | <input type="checkbox"/> None |
| <input type="checkbox"/> Chronic itching | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Menstrual irregularity | |

Are you unable to tolerate any of the following.

- | | | | |
|--|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Cigarette smoke | <input type="checkbox"/> Perfume | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Caffeine |
|--|----------------------------------|----------------------------------|-----------------------------------|

Patient Name _____ DOB _____ Date _____

Review of Systems

Please check if you have, or have had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.

Constitutional

- | | | |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Weight | <input type="checkbox"/> Appetite | <input type="checkbox"/> Sense of wellbeing |
| <input type="checkbox"/> Energy level | <input type="checkbox"/> Strength | <input type="checkbox"/> Ability to sleep |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Libido <input type="checkbox"/> None |

Eyes, ears, nose, mouth, throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Vision loss | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Vertigo/dizziness | <input type="checkbox"/> Gingivitis |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Blind spots | <input type="checkbox"/> Chronic stuffy nose | <input type="checkbox"/> Neck stiffness or swelling |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> None |
| <input type="checkbox"/> Eye discharge | <input type="checkbox"/> Recurrent sinus infection | |

Heart and blood vessels

- | | | |
|---|--|--|
| <input type="checkbox"/> Chest wall pain | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Short of breath w/ mild exercise | <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Leg pain when walking |
| <input type="checkbox"/> Short of breath lying flat | <input type="checkbox"/> Vessel inflammation | <input type="checkbox"/> Anemia <input type="checkbox"/> None |

Lungs

- | | | |
|--|---|---|
| <input type="checkbox"/> Painful breathing | <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> None |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Coughing sputum | |

Musculoskeletal

- | | | |
|--|--|--|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Hot/red muscles or joints |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Limited range of motion |
| <input type="checkbox"/> Bone loss/fractures | <input type="checkbox"/> Joint pain | <input type="checkbox"/> None |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Morning stiffness | |

Neurologic and psychological

- | | | |
|---|--|---|
| <input type="checkbox"/> Seizures/convulsions | <input type="checkbox"/> Incoordination | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> Suicidal history |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Anxiety | <input type="checkbox"/> None |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Depression | |

Endocrine

- | | | |
|---|--|--|
| <input type="checkbox"/> Breast enlargement – men | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Waking at night |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Spacey feeling after food | <input type="checkbox"/> Swelling <input type="checkbox"/> None |

Patient Name _____ DOB _____ Date _____

Women's Health

Menstrual History

Age menses began: _____ Date of last menstrual period: _____
 Length of cycle: _____ Duration of flow: _____
 Date of last PAP: _____ Any history of irregular PAPs? Yes No
 What best describes your current menstrual cycle:
 Regular Irregular Stopped Heavy Painful Other
 Please describe any PMS symptoms you experience: _____

Sexual History

Are you sexually active? Yes No Are you in a monogamous relationship? Yes No
 Have you ever had an STD screen? Yes No Have you ever had an STD? Yes No
 If yes, please list: _____

Please check the box if you have, or have had, any of the following.

- Pain with sex Vaginal discharge Any sores, warts, or lesions
 Concerns about libido Hysterectomy Recurrent urinary tract infections
 Recurrent yeast infections

Fertility and Contraception

Number of pregnancies: _____ Any problems with pregnancies? Yes No
 Number of births: _____ Any concerns regarding fertility? Yes No
 Are you currently trying to get pregnant? Yes No
 If no, please describe your current method of birth control: _____

Breast Health

Please check the box that applies to you.

- Breast implants Rash Self breast exams
 Lumps or nodules Fibrocystic changes Clinical breast exams
 Nipple discharge None Annual mammograms Date last test: _____

Perimenopause/Menopause

Age menopause began: _____

Please check the box that applies to you.

- Hot flashes Low libido Fatigue Joint/body pain Change in memory/cognition
 Insomnia Irregular bleeding Palpitations Mood changes None
 Vaginal dryness Heavy bleeding Urinary Tract Infections Depression Anxiety
 Pain with sex Incontinence

Please describe any current treatment: _____

Bone Health

Please check the box that applies to you.

- Bone fracture Limited physical activity History of eating disorders Weigh < 127lbs
 Smoker No menses for > 1yr

Patient Name _____ DOB _____ Date _____

Personal Biographical Review

In the course of our hurried lives, we often rush past significant lessons. Patterns in our biographies, if reflected upon, can yield important lessons that can motivate us to make overdue changes and fortify us as we move toward a healthier future.

Take a few pieces of regular 8" x 11" lined paper and number every OTHER space with the numbers 0 up to your age. (Therefore, a 40 year old person needs 82 lined spaces). Each year of your life (starting with year 0 which you spent in your mother's womb) is budgeted two lines.

The therapeutic exercise is designed for you to reflect upon your life and record in brief anything significant in the limited spaces. For example, consider formative events of an interpersonal nature, such as births of siblings, deaths of important people in your life, divorces, marriages, lessons learned, traumatic events or positive peak experiences. Note all events you are proud of as well as events you regret. Write down the defining events of your life. Be sure to include any symptoms, illnesses, hospitalizations and surgeries as well. For men with military history, if traumatic episodes are too painful (PTSD) to discuss in detail, simply note that you do not wish to go into detail.

Filling in this chronological history form may take up to one hour. Do not be discouraged by this challenge. This will be time well invested, for by considering the patterns and defining moments of your life, you and Dr. Hopewell can discern important formative connections. This mutual detective work should uncover clues that will lead you in the direction of improved health and well-being. As is the case with every other part of this health questionnaire, your biographical review will be held in strict confidence.

Mood Inventory

Please take a few deep breaths and slow down before answering the following eleven (11) questions. Read the questions carefully before answering honestly. Your answers should reflect your general feeling over the past week.

- 1) I do not feel sad.
I feel sad.
I am so sad all the time and I can't snap out of it.
I am so sad and or unhappy that I can't stand it.

- 2) I am not particularly discouraged about the future.
I feel discouraged about the future.
I feel I have nothing to look forward to.
I feel that the future is hopeless and that things cannot improve.

- 3) I do not feel like a failure.
I feel I have failed more than the average person.
As I look back on my life, all I can see are a lot of failures.
I feel I am a complete failure as a person.

Patient Name _____ DOB _____ Date _____

- 4) I get as much satisfaction out of things as I used to.
I don't enjoy things the way I used to
I don't get real satisfaction out of anything anymore.
I am dissatisfied or bored with everything.
- 5) I don't feel particularly guilty.
I feel guilty a good part of the time.
I feel guilty most of the time.
I feel guilty all of the time.
- 6) I don't feel like I am being punished.
I feel I may be punished.
I expect to be punished.
I feel I am being punished.
- 7) I don't feel disappointed in myself.
I am disappointed in myself.
I am disgusted with myself.
I hate myself.
- 8) I don't feel I am any worse than anyone else.
I am critical of myself for my weaknesses and mistakes.
I blame myself all the time for my failures.
I blame myself for everything that happens.
- 9) I don't have any thoughts of killing myself.
I have thoughts of killing myself, but I would not carry them out.
I would like to kill myself.
I would kill myself if I had the chance.
- 10) I don't cry any more than usual.
I cry more than I used to.
I cry all the time.
I used to be able to cry, but now I can't cry even though I want to.
- 11) I am not more irritated by things than I ever am.
I am slightly more irritated now than usual.
I am quite annoyed or irritated a good deal of the time.
I am irritated all the time now.

Patient Name _____ DOB _____ Date _____