PATIENT NAME:

All Around Health LLC

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All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them with your doctor.

ADULT MEDICAL INTAKE

What are your most important health problems? List in order of importance.

1)_____

2)_____

3)_____

4)_____

5)_____

Are you currently receiving healthcare? Yes No

If yes, please list providers

_____

_____

_____

If no, when and where did you last receive medical or health care?

_____

What was the reason?

_____

List medications and supplements that you are currently taking: (Including dose/time)

_____

_____

_____

_____

PATIENT NAME:

GENERAL HEALTH:

Height: _____ Weight: _____ Weight one year ago: _____

Maximum weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies:_____

_____

Exercise: □ Yes □ No If so what kind and how often: _____

_____

Do you:

Watch TV: □ Yes □ No If so how many hours? _____

Read: □ Yes □ No If so how many hours? _____

Computer: □ Yes □ No Is so how many hours? _____

Do you have a religious or spiritual practice? □ Yes □ No

If so what kind? _____

Would you like to include aspects of your religion/spirituality into your health care?

□ Yes □ No □ Maybe

Is your home a safe place (physically and emotionally)? □ Yes □ No

Please explain: _____

Have you ever been physically or emotionally abused? □ Yes □ No

Do you have concerns with abuse or violence in your life now? □ Yes □ No

NUTRITION:

Do you follow a specific diet (vegetarian, vegan, gluten-free, etc…) □ Yes □ No

Please describe: _____

_____

Do you feel satisfied with your ability to prepare healthy, tasty foods?

_____

Are you needing help with any of the following:

Losing weight: □ Yes □ No Gaining weight: □ Yes □ No

Maintaing weight: □ Yes □ No Healthy eating: □ Yes □ No

What foods do you love: _____

What foods do you dislike: _____

What do you drink on a regular basis: _____

Do you have any concerns about your relationship with food?

FAMILY HISTORY:
Do you or anyone in your family have a history of any of the following?
(Please check and say who)
□ Cancer _____ □ Diabetes _____ □ Epilepsy _____
□ Kidney disease _____ □ Stroke _____ □ Anemia _____
□ Tuberculosis _____ □ Arthritis _____ □ Glaucoma _____
□ Heart disease _____ □ High Blood Pressure _____
□ Asthma _____ □ Hay Fever _____ □ Hives _____

Any other relevant family history?
_____

Mother (age or age at death):
General Health: Poor Average Good Excellent

Father (age or age at death):
General Health: Poor Average Good Excellent

Sibling (age or age at death): Sex:
General Health: Poor Average Good Excellent

Sibling (age or age at death): Sex:
General Health: Poor Average Good Excellent

Sibling (age or age at death): Sex:
General Health: Poor Average Good Excellent

CHILDHOOD ILLNESSES:
Please circle whether you had any of the following as a child:

Rheumatic fever Diptheria Scarlet fever Measles
Chicken pox German Measles Mumps
Anything Chronic in nature: (Ear infections, Strep Throat, ect…)
_____
VACCINATIONS:
Were you fully vaccinated as a child: □ Yes □ No

If no, which vaccines have you received?

Date of last Tetanus booster: _____

Do you receive seasonal flu vaccines: □ Yes □ No

HOSPITALIZATIONS / SURGERY / IMAGING:

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

Any significant injuries:

_____ Year _____

_____ Year _____

_____ Year _____

Any history of abnormal blood tests: □ Yes □ No

If so when and what test: _____

_____

Have you had blood tests in the last 5 years? □ Yes □ No

ALLERGIES:

Are you hypersensitive or allergic to:

Drugs? What type of reaction?

_____

Any foods? What type of reaction?

_____

Any environmental? What type of reaction?

_____

Any chemical? What type of reaction?

_____

Any seasonal or chronic complaints? When? What type of reaction?

_____

_____

_____

_____

PATIENT NAME:

REVIEW OF SYSTEMS

Please circle for any below: ***Y = Current condition P = Past condition***

Skin

Rashes	Y P	Eczema/hives	Y P	Itching	Y P
Acne/boils	Y P	Color Changes	Y P	Night sweats	Y P
Lumps	Y P				

Head

Headache	Y P	Head Injury	Y P

Eyes

Eye pain	Y P	Impaired vision	Y P	Double vision	Y P
Glaucoma	Y P	Tearing/dryness	Y P	Cataracts	Y P
Glasses	Y P	Contacts	Y P		

Ears

Ringing	Y P	Impaired Hearing	Y P	Earache	Y P
Dizziness	Y P	Frequent Infections	Y P		

Nose and Sinuses

Nose bleeds	Y P	Frequent colds	Y P	Hay fever	Y P
Stuffiness	Y P	Sinus Problems	Y P		

Mouth and Throat

Hoarseness	Y P	Frequent sore throats	Y P	Dental cavities	Y P
Gum problems	Y P				

Neck

Lumps	Y P	Swollen glands	Y P	Goiter	Y P
Pain/Stiffness	Y P				

Respiratory

Cough	Y P	Spitting up blood	Y P	Wheezing	Y P
Sputum	Y P	Breathing problems	Y P	Bronchitis	Y P
Asthma	Y P	Pain on breathing	Y P	Tuberculosis	Y P
Pneumonia	Y P	Shortness of breath	Y P	Emphysema	Y P
Smoking	Y P	How many packs/day: _____		Smokeless	Y P
Year began: _____		Year quit: _____			

Cardiovascular

Angina	Y P	Heart disease	Y P	Palpitations	Y P
Murmurs	Y P	High blood pressure	Y P	Rheumatic	
Chest pain	Y P	Swelling of ankles	Y P	fever	Y P

Gastrointestinal

Heartburn	Y P	Trouble swallowing	Y P	Blood in stool	Y P
Nausea	Y P	Change in thirst	Y P	Jaundice	Y P
Vomiting	Y P	Change in appetite	Y P	Liver disease	Y P
Ulcer	Y P	Belching/passing gas	Y P	Loose stools	Y P
Hemorrhoids	Y P	Gall bladder disease	Y P	Hard stool	Y P

Bowel movements: How often? _____ Is this a change? _____

Pain with bowel movements Y P

Musculoskeletal

Arthritis	Y P	Joint pain or stiffness	Y P	Broken bones	Y P
Osteopenia	Y P	Muscle pain/cramps	Y P	Osteoporosis	Y P

Peripheral vascular

Varicose veins	Y P	Thrombophlebitis	Y P	Cold hands/feet	Y P
Deep leg pain	Y P				

Neurological

Fainting	Y P	Loss of memory	Y P	Muscle weakness	Y P
Seizure	Y P	Numbness/tingling	Y P	ADD/ADHD	Y P
Paralysis	Y P	Family Hx of stroke	Y P		

Endocrine

Hypothyroid	Y P	Excessive thirst	Y P	Excessive hunger	Y P
Hyperthyroid	Y P	Family Hx of diabetes	Y P	Heat/cold intolerance	Y P
Diabetes	Y P				

Blood

Anemia	Y P	Easy bleeding	Y P	Easy bruising	Y P

Urinary

Kidney stones	Y P	Frequency at night	Y P	Increased frequency	Y P
Pain w/ urination	Y P	Inability to hold urine	Y P	Frequent infections	Y P

Female Reproductive

Age menses began? _____ Average # of days? _____ Length of cycle? _____

Last PAP? _____ Normal or Abnormal? _____
History of abnormals? _____ When and what treatment? _____

Herpes	Y P	Bleeding btwn periods	Y P	Irregular cycles	Y P
Genital warts	Y P	Pain during intercourse	Y P	Sexual difficulties	Y P
Painful menses	Y P	Menopausal symptoms	Y P	Difficulties conceiving	Y P
Excessive flow	Y P	Sexually transmitted infections		Y P	
Herpes	Y P	Are you sexually active		Y P	
Birth control	Y P	Type of birth control: _____			

Do you have any questions about birth control?

Sexual orientation: Heterosexual Bisexual Homosexual

Last time screened for sexual transmitted infections? _____
What tests and results (if known):_____

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

Any birth trauma or difficulties?

Did you breastfeed? _____ How long? _____
Any difficulties? _____

Do you do self breast exams Y P Lumps Y P
Breast pain/tenderness Y P Nipple discharge Y P
Family history of breast cancer? _____

If yes, which relative: _____ Age of diagnosis: _____
Type/treatment: _____

Last mammogram date: _____ Results: _____

Male Reproductive
Do you perform testicular self exams? _____ Frequency? _____

Hernias	Y P	Testicular masses	Y P	Testicular pain	Y P
Discharge	Y P	Prostate concerns	Y P	Lesions or sores	Y P
Are you sexually active?	Y P			Sexual difficulties	Y P
Sexually transmitted infections	Y P				

Do you use any form of protection? _____
Do you have any questions about birth control/ sexually transmitted infection protection?

Sexual orientation: Heterosexual Bisexual Homosexual

Last time screened for sexual transmitted infections? _____
What tests and results (if known):_____

Emotional

Depression	Y P	Anxiety / nervousness	Y P	Anti-depressants	Y P
Tension	Y P	Mood swings	Y P	Panic attacks	Y P
Drug abuse	Y P	Alcohol abuse	Y P	Eating disorder	Y P
Counseling/therapy	Y P				

Is there anything else that you think I should know in order to provide you the best possible care?

Successful health care is only possible when the doctor works toward a complete understanding of the client's physical, mental, and emotional well-being. Answering the following questions will help me create recommendations that are effective and appropriate. I appreciate your time, thoughtfulness, and honesty in completing this overview.

Why did you chose to see a Naturopath?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

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

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive or do not support your long-term health goals?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and ability to implement our health recommendations?

Do you feel you have a consistent support system for yourself that will enhance the beneficial lifestyle changes you will be making, whom would that be?