

### Patient Profile

Please fill out the following questionnaire. These questions are formulated to help your physician to understand about your health and be able to provide the proper treatment. Be advised that this information is confidential and will not be released without your Permission. PLEASE PRINT

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Occupation \_\_\_\_\_ SSN \_\_\_\_\_

Date of birth \_\_\_/\_\_\_/\_\_\_ SEX M F Height \_\_\_\_\_ Weight \_\_\_\_\_ Single \_\_\_ Married \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of the Spouse/partner \_\_\_\_\_ Closet Relative or emergency contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

IF YOU ARE FILLING OUT HIS FORM FOR A PATIENT, WHAT IS YOUR RELATIOSHIP TO PATIENT? \_\_\_\_\_ Name \_\_\_\_\_

Phone # \_\_\_\_\_

Referred by \_\_\_\_\_

What is the major complaint you are seeking help for? List in order of importance

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Has there been any change in your health within the past year? \_\_\_\_\_

Last physical examination was on \_\_\_\_\_

Are you now under the care of a physician/chiropractor/ naturopath/osteopath/etc? Y/N  
And what for \_\_\_\_\_

The name and address of physician \_\_\_\_\_

\_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Have you had any serious illness, oppression, or been hospitalized in the past?

Name of condition	Date	Reason for procedure	Results
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____

Are you taking any medicine(s) including non-prescription medicine/Vitamins/herbs/supplements? Y/N

Name	Dose (mg/ml)	Since how long	Reason	who prescribed
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____

Do you have or had the following conditions?

1. Damaged heart valves or artificial heart valves

Y/N \_\_\_\_\_

2. Murmur or rheumatic heart disease

Y/N \_\_\_\_\_

3. Cardiovascular disease (heart trouble, angina, Coronary insufficiency, coronary occlusion, High blood pressure (\_\_\_\_\_ mm/hg), Arteriosclerosis, stroke),

4. Low Pressure (\_\_\_\_\_ mm/Hg)

Y/N \_\_\_\_\_

**Women**

**Menses**

First day of Menarche \_\_\_\_\_

Are you pregnant?

Y/N \_\_\_\_\_

5. Do you have any problems associated with your menstrual period? Y/N \_\_\_\_\_

How many days is your cycle?

\_\_\_\_\_ Y/N \_\_\_\_\_

6. Are you nursing? Y/N \_\_\_\_\_

7. Did you ever nurse? Y/N \_\_\_\_\_

8. How many pregnancies did you have? Natural/ C section Y/N \_\_\_\_\_

9. Are you taking birth control pills? If yes, how long \_\_\_\_\_

10. What other methods do you use for protection including your husband/partner? \_\_\_\_\_

12. Were there any miscarriages or abortions? If yes, were they natural or induced by what \_\_\_\_\_

13. Is there any family member who has similar condition as yours? If so, what is it? \_\_\_\_\_

14. Is there any family member who has different condition than your? If so, what is it? \_\_\_\_\_

15. Last mammogram was \_\_\_\_\_

16. Last Pap exam \_\_\_\_\_

**Male**

Last prostate exam was \_\_\_\_\_

Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

**FAMILY History**

# Of family members/ children	Name	ages
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- 1.
- 2.
- 3.
- 4.

Any medical problem any of the family member has? List

- 1.
- 2.
- 3.

**Personal History:**

How committed are you to change your health?

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Are you allergic to any food, drugs, pollen grass, seasonal allergy etc? Describe the reaction to

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Any hobbies do you have and how often do you do?

- 1.
- 2.
- 3.
- 4.

Is there any condition, disease or problem that is not listed above that you think I should know, please explain?

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I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to the best of my knowledge. I will not hold my doctor or any other member of the staff, responsible for any errors or omissions that I have made in the completion of this form. **I understand that I am responsible for all the costs of the Naturopathic medical treatments and medicine/supplements and agree that I am personally responsible for all costs.** I hereby authorize the Naturopathic Medical Office to administer such as medications/supplements and perform such diagnostic and therapeutic procedures as may be necessary for my medical care.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of the Patient