



## Current Health Concerns

Please list by order of importance to you. (Attach another list if necessary)	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe when and where

Has anything changed or gotten worse?

Please state your travel history and place of birth.

## Personal & Family Health History

Date of last physical exam?	Date of last Dexa Scan (bone density scan)?
Date of most recent blood work?	Date of last colonoscopy?
Mother: <input type="checkbox"/> Living <input type="checkbox"/> Deceased    Age: _____ Cause if deceased: _____	Sibling: Y/N    Number living: _____ Number deceased: _____
Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased    Age: _____ Cause if deceased: _____	Gender: _____    Age(s): _____    Cause(s) if deceased: 1. _____ 2. _____ 3. _____ 4. _____

3.		
4.		
5		

<b>Personal &amp; Family Diagnosed Health Conditions</b>	YES	Who? Indicate self or a specific family member	Notes:
ADD/ADHD	<input type="checkbox"/>		
Alcohol/drug addiction	<input type="checkbox"/>		
Anemia	<input type="checkbox"/>		
Alzheimer's/Dementia	<input type="checkbox"/>		
Arthritis (Osteo or Rheumatoid?)	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>		
Autoimmune diseases	<input type="checkbox"/>		
Birth defects	<input type="checkbox"/>		
Blood disorder	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>		What kind?      Age diagnosed?
Cardiovascular Disease	<input type="checkbox"/>		
Depression	<input type="checkbox"/>		
Diabetes Type 2	<input type="checkbox"/>		
Diverticulosis	<input type="checkbox"/>		
Eating Disorder	<input type="checkbox"/>		
Eczema	<input type="checkbox"/>		
Epilepsy/Seizure Disorder	<input type="checkbox"/>		
Fibromyalgia	<input type="checkbox"/>		
Gallstones/Gall Bladder Disease	<input type="checkbox"/>		
Gout	<input type="checkbox"/>		
High Cholesterol	<input type="checkbox"/>		
HIV/Aids	<input type="checkbox"/>		
Hypertension	<input type="checkbox"/>		
Inflammatory Bowel Disease	<input type="checkbox"/>		
Kidney Disease	<input type="checkbox"/>		
Learning Disability	<input type="checkbox"/>		
Liver Disease - If Y, specify:	<input type="checkbox"/>		
Mental illness – If Y, specify:	<input type="checkbox"/>		
Neurologic disorder	<input type="checkbox"/>		
Osteopenia/Osteoporosis	<input type="checkbox"/>		
Stomach or Duodenal Ulcers	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>		
Thyroid disease	<input type="checkbox"/>		
Other:	<input type="checkbox"/>		

Prescribed medications and over the counter medications – attach a separate list if necessary

**Past Medical History**

Please list any hospitalizations, and any major past illnesses or injuries (e.g. broken bones, surgeries etc.)


Medication Name	Dose	When started?	Why?
1.			
2.			
3.			
4.			
5.			

**Drug Allergies?**

Any known medication allergies? Y/N \_\_\_\_\_

If Yes, which medications: \_\_\_\_\_

What allergic reaction symptoms do you experience? \_\_\_\_\_

**Supplements – please list all vitamins/botanicals, homeopathics, etc.**

Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started	Why
1.			
2.			
3.			
4.			
5.			

6.			
7.			
8.			
9.			
10.			

## Lifestyle and Social History

### Diet

Do you follow any special diet type or restrictions?	Are there foods you crave strongly?
What foods make you feel poorly? Explain:	What foods make you feel the best? Explain:
How would you describe your relationship with food?	

Number of meals a day:

Number of snacks a day:

Who typically cooks your food?

Where do you typically purchase your food?

Please list typical foods consumed daily – specify typical times of day for each:

Breakfast	
Lunch	
Dinner	
Snacks	
Sweets	
Water	<p>How much? Tap? filtered, bottled?</p> <p>Are you generally thirsty?</p>

Foods you avoid?

Primary sources of protein?

**List the foods you ate with in the last 24 hours:**

Breakfast:

Lunch:

Dinner:

**Please check the appropriate box below to indicate the frequency of consumption:**

	Daily	Weekly	Monthly	Occasionally (1-2x per mo)	Rarely (1-2x per yr)	Never
Sugar						
Artificial sweeteners						
Fast food						
Fried food						
Processed food						
Flour/baked goods						
Caffeine						
Soda?						
Alcohol?						

Notes/details:

**Habits**

Do you smoke cigarettes? Y/N	Packs per day?	Duration of habit?
	Past Use?	If so, how long ago did you quit?
Do you use recreation drugs? Y/ N	If Y, what type?	
	How often?	
	Past Use?	If so, how long ago did you quit?

Have you ever been treated for drug/alcohol addiction? Y/N	If Y, describe:	How long ago?
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## Exercise

Do you exercise regularly? Y/N	How often?	For how long?
What type of exercise(s) do you do?		

## Sleep

How many hours of sleep do you get regularly each night?	Time you go to bed?
Do you fall asleep easily? Y/N	Do you sleep soundly? Y/N
Do you wake rested? Y/N	Time you get up?
	What is your AM mood like?

Notes:

## Occupation

What is your occupation?	Do you like your work? Y/N
Number of hours worked per week:	Do you like your work environment? Y/N
	If no, please explain:

## Stress Level

Rate 1-10 (1 = Very Low, 10 = High)	Source(s) of stress:
What do you do to cope with stress?	

## Sense of Well-being

Rate your sense of wellbeing from 1-10 (1 = Very Low, 10 = High)	How would you define your emotional state?
What do you do to regularly support your health and well-being?	
What challenges do you face with your efforts to maintain health?	
Where do you feel you could use more support?	
Do you cry a lot?	
How do you express anger?	

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Do you have a history of suppressing desire or emotion?

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Do you consider that your complaint dates from any particular incident, aspect or disease?      Y                      N  
Please describe however trivial or irrelevant they may seem.

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### **PURE Naturopathic Healthcare**

**PURE Naturopathic Healthcare** is a cash-based practice that accepts cash, check or credit card payment. Payment is required on the day services are rendered. We do not file insurance claims but we will provide you with a “super-bill” that contains the diagnosis and procedure codes required for insurance reimbursement. Pure Health assumes no responsibility for services not reimbursed by your insurance company.

I have read, understand, and agree to the above policies:

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Please Print Your Name

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Signature \_\_\_\_\_ Date \_\_\_\_\_