CONFIDENTIAL PATIENT INFORMATION

Please print legibly. It is helpful to have a thorough intake to provide excellent naturopathic care. Please answer as honestly as possible. There is no judgment here.

Name: ____ D.O.B.__________________

Biological gender (circle): Male Female Preferred Pronoun or Names: ____________________

Address: ____

City:________________________________ State: ______________ Zip:__________________

Phone: _________________________ Email address: ________________________________

Preferred method of contact (circle): Email Phone

Emergency Contact: ____________________________________ Phone: __________________

How did you hear about us?:____

Are you establishing Dr. Ward-Selinger as your primary care provider? [ ] YES [ ] NO

If no, please complete below

PCP Name: ___________________________________ Phone: (_____)_________________

Address: _____________________________________ City:____________ State: __________

What is your preferred pharmacy?:____

HEALTH CONCERNS: List in order of importance

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

Are you currently under the care of any other health care practitioner? (Naturopathic Physician, Specialist, Chiropractor, Chinese medicine practitioner, massage therapist, psychiatrist, etc)*If yes*, please list below:

____

____

____

____

MEDICATIONS

List all pharmaceutical medications and supplements with dosages that you are currently taking

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

Please check any of the following that you take on a regular basis:

[ ] Antacids (Rolaids, Tums)
[ ] Antihistamines (Claritin, Benadryl
[ ] Cortisone (cream or pills)
[ ] Cough or Cold medications
[ ] Diet pills
[ ] Laxatives
[ ] Oral Contraceptives
[ ] Sleeping pills
[ ] Thyroid Medication
[ ] Pain Relievers (aspirin, Tylenol, Aleve, Motrin)
[ ] Others: ________________

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ALLERGIES

Are you allergic to any medications? [ ] YES [ ] NO

If yes, please list: ____

What is your reaction to these medications? ____

Do you have any other allergies to foods, drugs, or other allergens in your environment (e.g. cats, mold, dust, etc.)____

What allergies did you have as a child? ____

PAST MEDICAL HISTORY

What hospitalizations or surgeries have you had? Please give dates and reasons:

____
____
____

What diagnostic imaging studies have you had?

[ ] Bone Density Scan (DXA)
[ ] Colonoscopy/Sigmoidoscopy
[ ] CT Scan
[ ] Endoscopy
[ ] Electrocardiogram (ECG/EKG)
[ ] Electroencephalogram (EEG)
[ ] Echocardiogram
[ ] Laparoscopy
[ ] Mammogram
[ ] Thermography
[ ] Ultrasound
[ ] X-Ray
[ ] MRI
[ ] Others: _____________

Are you immunizations up to date? [ ] YES [ ] NO
Do you get an annual flu shot? [ ] YES [ ] NO

Have you had any of the following childhood illnesses?

[ ] Diptheria
[ ] German Measles
[ ] Measles
[ ] Mumps
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Strep Throat
[ ] Chicken Pox
[ ] Others: ____________________

What is your blood type? _______________ [ ] I don't know

SOCIAL HISTORY

Occupation____

Status (circle): Full Time / Part Time / Student / Retired / Disabled / Unemployed

Employer/School ____

Status: Single / Married / Long-term relationship / New Relationship / Separated / Divorced / Widowed

Living Arrangements: Alone / Spouse / Partner / Parents / Children / Friends / Other________________

Describe your support network: ____

____

HEALTH HABITS	Yes	No	If yes, for how long and/or how often per week?
Do you exercise?			
Do or did you smoke tobacco? (Past or present)			
Do you drink alcohol?			
Do you use recreational drugs?			
Have you ever been treated for drug/alcohol dependence?			Explain:
Do you drink coffee, soda, or tea?			
Do you follow any dietary modifications?			Describe:

GENERAL REVIEW					
Do you…	**Yes**	**No**		**Continued…**	
Sleep well?				Current weight	
Wake feeling rested?				Weight one year ago	
Eat three meals daily?				Max. adult weight, date?	
Enjoy your work?				Min. adult weight, date?	
Spend time outside?				Current height	
Take vacations?				Best energy level? (time of day)	
Watch television? Hours/week? Read? Hours/week?				Lowest energy level? (time of day)	

FOOD & DIET (Please describe your typical food intake)

Breakfast	Lunch	Dinner	Snacks	Beverages
				Water ______/day Filtered? Y N

Favorite foods: ____

List the 3 healthiest foods you eat during an average week: ______________________________

List the 3 “worst” foods you eat during an average week: ________________________________

What % of your diet is packaged/pre-made/to go? ________%

Do you read food labels? [ ] YES [ ] NO

Do you or have you ever had an eating disorder? [ ] YES [ ] NO

Please explain: ____

____

PAST & FAMILY MEDICAL HISTORY

Condition	Self	Father	Mother	Siblings	Grandparent	Child
ADD/ADHD						
Alcoholism						
Allergies						
Anemia/Blood Disorder						
Anxiety/Depression						
Arthritis						
Asthma						
Autoimmune Disease						
Cancer (type)						
Diabetes						
Drug/Other Addiction						
Epilepsy/Seizure						
Gallbladder Disease						
Gastrointestinal Disorder						
Glaucoma/Cataracts						
Gynecological Disorder						
Headaches/Migraines						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Hypoglycemia						
Infertility						
Kidney Disease						
Liver Disease						
Lung Disease / TB						
Pain, Chronic						
Neurological Disorder						
Skeletal Disorder						
Skin Disorder						
Stroke						
Thyroid Disorder						
Urinary Disorder						

Review of Systems (Please check the conditions that apply… **C = Current and P = Past**)

C	P	GENERAL	C	P	CARDIOVASCULAR	C	P	MUSCULOSKELETAL
		Fatigue			Chest pain/pressure			Arthritis
		Night Sweats			Palpitations			Joint pain
		Fever/Chills			Heart disease			Joint swelling
		Hot flashes			High blood pressure			Muscle pain
		Easy bleeding/bruising			Irregular heartbeat/ murmur			Muscle cramps/spasms
		Anemia			Swelling in the ankles			Muscle weakness
		Hot/Cold Intolerance						Back pain
		Changes to thirst/ hunger	**C**	**P**	**RESPIRATORY**			Sciatica
					Asthma			Osteopenia/osteoporosis
C	**P**	**HEAD/NECK**			Cough			Broken bones
		Headache/Migraine			Wheezing			
		Dizziness/vertigo			Shortness of breath	**C**	**P**	**NEUROLOGIC**
		Swollen lymph nodes			Difficulty breathing			Memory loss
		Tonsil stones			Pain with breathing			Difficult memory
		Neck pain/stiffness			Pneumonia			Numbness/tingling
		TMJ			Emphysema			Paralysis
		Head injury						Seizures
		Goiter/thyroid swelling	**C**	**P**	**GASTROINTESTINAL**			Tremor
					Abdominal pain			
C	**P**	**EYES**			Gas/Bloating	**C**	**P**	**MENTAL/EMOTIONAL**
		Blurriness			Diarrhea			Anxiety
		Cataracts			Constipation			Depression
		Glaucoma			Mucous in stool			Panic attacks
		Color blindness			Blood in stool			Treatment for mental health
		Vision changes			Undigested food in stool			Seasonal depression
		Dryness			Greasy/fatty stool			Poor concentration
		Itching eyes			Changes to bowel habits			Contemplation of suicide
		Eye pain			Pain with defecation			Critical of self
		Spots/floaters			Nausea			Critical of others
		Retinal detachment			Vomiting			Loneliness
					Stomach pain			Mood swings
C	**P**	**EARS**			Gall bladder disease			Tension, stress
		Hearing changes			Fatigue after eating			
		Itching in ears			Difficulty swallowing	**C**	**P**	**DERMATOLOGICAL**
		Infections			Heartburn/reflux			Acne
		Earache			Hepatitis			Boils
		Tinnitus, ringing			Liver disease			Eczema
					Parasites, type:			Psoriasis
C	**P**	**NOSE**			Fecal incontinence			Rashes
		Hayfever			Hemorrhoids			Fungal infections
		Nose Bleeds			BM #/day___ or #/week____			New lumps/bumps
		Runny nose						Hives
		Stuffy nose	**C**	**P**	**URINARY**			Hair loss
		Sinus problems			Pain with urination			Rosacea
					Difficulty urinating			Moles
C	**P**	**MOUTH/THROAT**			Blood in urine			Skin tags
		Bad breath			Urinary frequency			Skin cancer
		Cavities/fillings			Urinary urgency			Color changes
		Sore throat			Urinary incontinence			Other:
		Gum problems			Nighttime urination			
		Metallic taste			Urinary tract infections			
		Gum problems			Kidney infections			
		Teeth grinding						

C	P	**MALE REPRODUCTIVE**	C	P	**FEMALE REPRODUCTIVE**	C	P	**FEMALE REPRODUCTIVE**
		BPH			Abnormal pap			Age of first menses:
		Prostate issues			Irregular cycles			Average cycle time:
		Fertility concerns			Cramping			Average days of bleeding:
		Erectile concerns			Heavy bleeding			Last menstrual period:
		Ejaculation concerns			Blood clots			Are you menopausal: Y N
		Sexual difficulty			Bleeding between cycles			# of pregnancies:
		Penile discharge			Emotional changes			# of live births:
		Penile sores			Breast tenderness			# of miscarriages:
		Testicular masses			Breast lumps			# of abortions:
		Testicular pain			Nipple discharge			Date of last Gyn exam:
		Sexually transmitted infection			Fertility issues			Date of last STI testing:
		Sexually active			Sexually transmitted infection			Birth control type:
		Date of last genital exam:			Vaginal discharge			
		Date of last STI testing:			Sexually active			
		Birth control type:			Birth control type:			
					Pain with intercourse			
					Uterine fibroids			
					Ovarian cysts			
					PCOS			
					Endometriosis			
					Hysterectomy, full or partial			
					Decreased libido			
					Hormone replacement			

Sexual orientation (circle): Heterosexual Gay Queer Bisexual Transgender Abstinent

HEALTH GOALS AND EXPECTATIONS

What are your health goals?____

What is your level of motivation regarding your healing?____________________

What do you expect from your practitioner?______________________________

Thank you for taking the time to complete this form. We will do our best to help you.