ADULT BASIC HEALTH HISTORY FORMS

Today's Date (D/M/Y): ___/___/___ **Name: _____**

Date of Birth (D/N/Y) ___/___/___ **Sex (Male/Female): _____ Age: _____**

Address: _____

(Street#/P.O. Box) (Apt.#) (City) (postal code)

Email address: _____ **Home Telephone _____**

Work Telephone _____ **Cell Phone _____**

Occupation: _____ **Employer _____**

Date of last physical? _____ **General Practitioner(MD) _____**

Phone number: _____ **Fax Number:_____**

Emergency Contact (name/number): _____

List any specialist you have seen in the last 6 months:

_____

_____

LIST YOUR MAJOR HEALTH CONCERNS IN ORDER OF PRIORITY.

DIAGNOSIS/SYMPTOMS	DATE ONSET	CAUSE

Do you have coverage for naturopathic medicine? Yes/No/Unsure If yes, how much per year?

List any other natural therapies you are covered for: _____

Circle any that apply: Unemployment Insurance, Social Welfare, Workers Compensation, Disability Insurance

LIST ALL ALLERGIES: _____

What medications/supplements are you currently taking?

NAME	DOSE	DATE STARTED

List all surgeries you have had:

PROCEDURE	YEAR	COMPLICATIONS?

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List all major injuries you have sustained:

INJURY	YEAR	LONG TERM EFFECTS?

Which of the following conditions have you had? (Check all that apply)

Abscesses	Diabetes	High Blood Pressure	Hepatitis	Yellow Fever
Alcoholism	Emphysema	Influenza (flu)	Gingivitis	Sunstroke
Allergies	Epilepsy	Kidney Disease	Pleurisy	Stroke
Amnesia	Gallstones	Leukemia	Pneumonia	Syphilis
Arthritis	Gonorrhea	Malaria	Prostatitis	Thyroid Disease
Asthma	Gout	Measles	Rheumatic Fever	Tonsillitis
Cancer	Hey Fever	Miscarriage	Rubella	Tuberculosis
Chicken Pox	Heart Disease	Mononucleosis	Sexual Abuse	Typhoid
Cold Sores	Hepatitis	Mumps	Skin Disease	Venereal Warts
Depression	Genital Herpes	Parasites	Strep Throat	Whooping Cough

Which of the following do you currently use now or have you used in the past?

Substance Used	Past?	Now?	How Frequently
Tobacco			
Hormones			
Cortisone			
Sedatives			
Recreational Drugs			
Antacids			
Antibiotics			

Have you ever been chronically exposed to toxic chemicals while at work, home or traveling? **Yes/No**

Which of the following have affected your blood parents, grandparents or siblings?

Alcoholism	Depression	Gallstones	Thyroid Disease	Stroke
Allergies	Diabetes	Glaucoma	Kidney Disease	Alzheimer's
Blood Disorder	Gout	Mental Illness	High Cholesterol	Arthritis
Eczema	Psoriasis	Multiple Sclerosis	Osteoporosis	Asthma
Emphysema	Heart Disease	Epilepsy	High Blood Pressure	Parkinson's Disease
Cancer	Crohn's Disease	Ulcerative Colitis	Irritable Bowels	

Other? _____

Rate the general state of your health (circle): Excellent Good Average Fair Poor

Rate your average energy level from 1-10: (10 = superb 1= terrible)

At what time of day/night is your energy BEST? _____ **WORST?** _____

Do you exercise? Yes/No If yes specify type (ie. Strengthening versus cardio) and time on a weekly basis:

_____

What if any is your main interest/hobby/passion? _____

Have you had any adverse effects from a vaccination? Yes/No **Have you had any flu shots?** Yes/No

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Please list the most significant, stressful, events in your life.

1. _____ Date: _____
2. _____ Date: _____

<u>CIRCLE</u> THE MOST APPROPRIATE DESCRIPTION OF YOUR DIGESTION IN GENERAL:

Average Frequency of Bowel Movements Daily: 1x 2x 3x less than once
The odor of my bowel movements is: odorless mild odor strong odor
The form of my bowel movement is: hard pellets thin ribbons watery Large single soft

DIET HISTORY

How many meals do you generally eat each day?
How long do you take to eat an average meal?
List any foods you exclude from your diet and why?
Who prepares your food?
How many glasses water/day?

_____

Circle any food you crave: sweet, salty, fatty, and/or sour

List foods that upset your digestion: _____

Are you satisfied with your diet? Yes/No **Are you satisfied with your lifestyle?** Yes/No
Do you tend to be thirsty?: Yes/No I drink _____ glasses of water daily.
Do you prefer drinks hot, cold or room temperature? _____

How often do you use any of the following? WRITE how many per day/week/month (ex. 3 per week)

Coffee		**Pop**	
Margarine		**Wheat**	
Juice		**Alcohol**	
Nuts/Seeds		**Beans/Lentils**	
Aspartame		**Added Sugar**	
Table Salt		**Dairy Products**	

Please list any of these you no longer used but used in the past for more than 6 months:

_____

Have you ever seen a (CIRCLE): Gastroenterologist, Dermatologist, Endocrinologist, Rheumatologist, Neurologist, Oncologist, Gynecologist, Psychiatrist, Cardiologist, Nephrologist, Ophthalmologist

What type of cell do you have and where do you carry it? _____

PLEASE PROVIDE A 24 HOUR DIET RECALL (as detailed as you can) BELOW: