SALMON CREEK CLINIC

Natural Health Care

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Name _____ Date _____
Age_____ Date of Birth_____ Sex F M
Address _____
City _____ State _____ Zip Code _____
Telephone (home) _____(work)_____
E-mail _____
Occupation_____ Hours per wk_____ Retired _____
Employer_____ Education _____

Are you: Married___ Separated___ Divorced____ Widowed____ Single____
Significant Partnership_____
Live With: Spouse___ Partner___ Relatives___ Friends___ Alone___ Parents___

Next of Kin or other to reach in an emergency_____
Relationship_____ Address _____
Phone_____

Health History Questionnaire

Holistic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. **Print** all information and mark anything you don't understand with a question mark.
When and where did you last receive medical or health care?_____
_____
What was the reason?_____

What are your most important health problems? List as many as you can in order of importance.
1.)_____
2.)_____
3.)_____
4.)_____
5.)_____

For All New Patient Files:
The naturopathic community is interested in furthering the goal of naturopathic medicine through scientific investigations and research. Would you consent to our use of your medical records by qualified investigators under protocols approved by an appropriate Institutional Review Board? Your anonymity will be guaranteed. **Yes**_____ **No**_____
Signature _____ **Date** _____

Family History

Check those applicable	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health G:good F:fair P:poor	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

For the following sections, please circle Y=yes or N=no

Childhood Illness

Scarlet Fever Y N Diphtheria Y N Rheumatic Fever Y N
Mumps Y N Measles Y N German Measles Y N
Other_____

Hospitalization and Surgery

What hospitalizations or surgeries have you had? _____
_____

X-Rays and Special Studies

X-rays, CAT Scans, or MRI's you have had: _____
_____
Electrocardiogram Y N Electroencephalogram Y N

Immunizations

Polio Y N Pertussis Y N
Tetanus shot (not antitoxin) Y N Diphtheria Y N
Measles/Mumps/Rubella Y N Other _____

Allergies

Please list any foods, drugs, or other allergens that you know of: _____
_____

Current Medications

Do you take or use?
Laxatives Y N Pain Relievers Y N Antacids Y N
Cortisone Y N Appetite Suppressants Y N Sleeping Pills Y N
Tranquilizers Y N Thyroid Medication Y N
Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking: _____
_____

Review of Symptoms

Y = a condition you have now. **N** = never had. **P** = a condition you have had in the past. For the following, please circle.

General

Weight	_____
Weight 1 yr. ago	_____
Maximum Weight	_____
When	_____
Height	_____
Fatigue	Y P N

Skin

Rashes	Y P N
Other skin conditions	Y P N
Itching	Y P N
Color Change	Y P N
Lumps	Y P N
Night Sweats	Y P N

Head

Headaches	Y P N
Head Injury	Y P N

Eyes

Impaired Vision	Y P N
Glasses or Contacts	Y P N
Eye Pain	Y P N
Tearing	Y P N
Dryness	Y P N
Double Vision	Y P N
Glaucoma	Y P N
Cataracts	Y P N

Ears

Impaired hearing	Y P N
Ringing	Y P N
Earaches	Y P N
Dizziness	Y P N

Nose and Mouth

Frequent Colds	Y P N
Sore Tongue	Y P N
Gum Problems	Y P N
Hoarseness	Y P N
Teeth Problems	Y P N
Sinus Problems	Y P N

Neck

Lumps	Y P N
Swollen Glands	Y P N
Goiter	Y P N
Pain or Stiffness	Y P N

Respiratory

Cough	Y P N
Sputum	Y P N
Spitting up Blood	Y P N
Wheezing	Y P N
Asthma	Y P N
Bronchitis	Y P N
Pneumonia	Y P N
Pleurisy	Y P N
Emphysema	Y P N
Difficulty Breathing	Y P N
Pain when Breathing	Y P N
Shortness of Breath	Y P N
At night	Y P N
Lying down	Y P N
Tuberculosis	Y P N

Cardiovascular

Heart Disease	Y P N
Angina	Y P N
High Blood Pressure	Y P N
Murmurs	Y P N
Rheumatic Fever	Y P N
Chest Pain	Y P N
Swelling in ankles	Y P N
Palpitations, Fluttering	Y P N

Gastrointestinal

Trouble Swallowing	Y P N
Heartburn	Y P N
Change in Thirst	Y P N
Change in Appetite	Y P N
Nausea	Y P N
Vomiting	Y P N
Vomiting Blood	Y P N
Bowel Movements	
How Often	_____
Is this a change	_____
Blood in Stool	Y P N
Belching or passing gas	Y P N
Jaundice (yellow skin)	Y P N
Liver Disease	Y P N
Gall Bladder Disease	Y P N
Ulcer	Y P N
Hemorrhoids	Y P N

Urinary

Pain on Urination Y P N
Increased Frequency Y P N
Frequency at Night Y P N
Inability to hold urine Y P N
Frequent Infections Y P N
Kidney Stones Y P N

Female Reproduction

Age Menses Began _____
Average Number of days _____
Length of Cycle _____
Bleeding Between Periods Y P N
Are Cycles Regular Y P N
Pain during intercourse Y P N
Painful Menses Y P N
Vaginal problems Y P N
Excessive Flow Y P N
Birth Control Y P N
What Type? _____
Number of Pregnancies _____
Number of Live Births _____
Number of Miscarriages _____
Number of Abortions _____
Difficulty Conceiving Y P N
Menopausal Symptoms Y P N
Are you Sexually Active Y P N
Sexual Difficulties Y P N
Venereal Disease Y P N
Heterosexual _____
Bisexual _____
Homosexual _____

Breasts

Do You Self Exam Y P N
Lumps Y P N
Pain (or tenderness) Y P N
Nipple discharge Y P N

Male Reproductive

Hernias Y P N
Testicular Masses Y P N
Testicular Pain Y P N
Penis problems Y P N
Are you sexually Active Y P N
Sexual Difficulties Y P N
Prostate Disease Y P N
Venereal Disease Y P N
Discharge or Sores Y P N
Heterosexual _____
Bisexual _____
Homosexual _____

Musculoskeletal

Joint Pain or Stiffness Y P N
Arthritis Y P N
Broken Bones Y P N
Muscle Spasms Y P N
Weakness Y P N

Peripheral Vascular

Deep Leg Pain Y P N
Cold Hands and Feet Y P N
Varicose Veins Y P N
Thrombophlebitis Y P N

Neurologic

Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle Weakness Y P N
Numbness or Tingling Y P N
Loss of Memory Y P N

Emotional

Depression Y P N
Mood Swings Y P N
Anxiety Y P N
Tension Y P N

Endocrine

Hypothyroid Y P N
Heat or Cold Intolerance Y P N
Excessive Thirst Y P N
Excessive Hunger Y P N

Blood

Anemia Y P N
Easy Bleeding or Bruising Y P N

Habits

What are your main hobbies and interests? _____
_____
_____
_____
Do You Exercise? Y N
What Forms? _____
_____
How Often do You Exercise?____
_____
Do you eat three meals daily Y N

Awaken rested Y N
Sleep well Y N
Average 6-8 hours sleep Y N
Enjoy your work Y N
Spend time outside Y N
Watch television Y N
How many hours a day _____
Read Y N
How many hours a day _____
Take vacations Y N
Been treated for drug dependence Y N
Use recreational drugs Y N
Use alcoholic beverages Y N
Been treated for alcoholism Y N
Use tobacco Y N