Seattle Naturopathic and Acupuncture Center
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Health History Questionnaire

By completely filling out this form you will help us to help you. All answers will be *absolutely confidential*. If you have any questions please ask. Thank you.

Today's Date _____
Name_____ M F
Age _____ Birth date _____
Home Address_____City_____
State_____Zip code _____
Home Phone _____ Work Phone _____
E-Mail Address _____
If client is a child:
Father's Name _____ Mother's Name _____
Spouse's Name_____ Children (Name/Age)_____
Occupation_____
Names of Other Healthcare Providers:
Medical Doctors _____Naturopathic Doctors_____
Chiropractor_____Others_____
_____
Who referred you to our Clinic?
_____

Your Main Health Concern
Why are you coming to our Clinic today?

When did your problem(s) begin (be specific)?

Your Past Medical History (Please circle and date)

Cancer	Diabetes	Venereal Disease
High Blood Pressure	Seizures	Surgeries
Heart Disease	Hepatitis	Other Major Illness
Rheumatic Fever	Thyroid Disease	

Significant Trauma (auto accidents, falls, other)
Allergies (drugs, chemicals, foods)

Family Medical History
Please indicate family member, and if on father's (F) or mother's (M) side of the family.

Cancer	High Blood Pressure	Asthma
Diabetes	Heart Disease	Allergies
Seizures	Stroke	

Occupational Stress (chemical, physical, psychological)

Describe Your Weekly Exercise

Current Medicines
List all prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs.

Known Allergies

Diet
Are you or have you ever been on a restricted diet? If so, what kind?

Please describe your average daily diet:
Morning

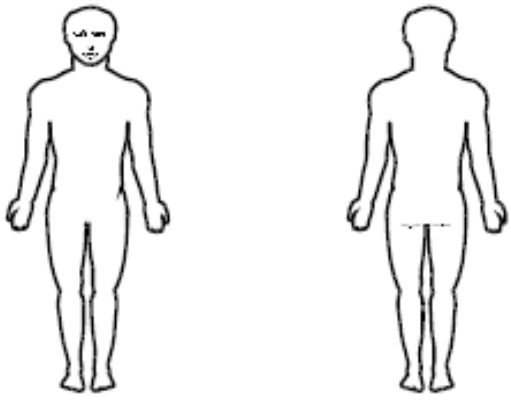
Afternoon

Evening

How many packs of cigarettes do you smoke a day?

How much coffee, tea, cola, or alcohol do you drink per week?

Indicate Painful or Distressed Areas



Please check if the following symptoms are a current or recurring problem.

General

Poor appetite	Night sweats	Weight gain
Poor sleep	Sweat easily	Weight loss
Fatigue	Change in appetite	Chills
Cravings	Bleed or bruise easily	Fevers
Strong thirst	Peculiar tastes or smells	
Sudden energy drop (time?)		

Skin and Hair

Rashes	Change in hair or skin texture	Recent moles
Itching	Loss of hair	Ulcerations
Eczema	Dandruff	Pimples
Other hair or skin problems?		

Head, Eyes, Ears, Nose, And Throat

Headaches	Night blindness	Sinus problems
Neck pain	Color blindness	Nose bleeds
Concussions	Cataracts	Jaw clicks or pain
Eye pain	Earaches	Tooth pain
Eye strain	Poor hearing	Mercury tooth fillings
Blurry vision	Ringing in ears	Recurrent sore throats
Using glasses	Sores on lips or tongue	Facial pain

Cardiovascular

High blood pressure	Fainting	Cold hands or feet
Low blood pressure	Chest pain	Swelling of hands
Irregular heartbeat	Varicose veins	Swelling of feet
Dizziness	Blood clots	

Respiratory

Difficulty breathing	Asthma	Coughing blood
Cough	Pain with a deep breath	Pneumonia
Bronchitis	Production of phlegm (color?)	Other problems

Gastrointestinal

Indigestion	Abdominal pain or cramps	Rectal pain
Gas	Nausea	Hemorrhoids
Bad breath	Vomiting	Blood in stool
Constipation	Chronic laxative use	Diarrhea

Genito-Urinary

Frequent urination	Unable to hold urine	Kidney stones
Urgency to urinate	Decrease in flow	Impotency
Pain on urination	Distinctive or odd color	Sores on genitals
Do you wake to urinate?	Blood in urine	Other problems

Gynecology and Pregnancy

____Age of first menses	Unusual menses	Irregular periods
____Duration of menses	Heavy	Painful periods
____Days between menses	Light	Vaginal discharge
____Date of start of last menses	Clots	Vaginal sores
____Date of last PAP exam	Breast tenderness	

Changes in body or emotions prior to menstruation?

Do you practice birth control? What type and for how long?_____
Number of pregnancies___ Number of births___ Miscarriages___
Abortions___

Musculoskeletal

Neck pain	Knee pain	Muscle pain
Back pain	Foot / ankle pain	Muscle weakness
Hand / wrist pain	Hip pain	
Shoulder pains	Other joint or bone problems?	

Neuro-psychological

Loss of balance	Depression	Concussion
Quick temper / irritable	Susceptible to stress	Seizures
Poor memory	Dizziness	Areas of numbness
Anxiety	Lack of coordination	

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

Comments

Please describe any other problems you would like to discuss.