

Beacon Naturopathic Health Center  
1842 Beacon Street, Suite 203  
Brookline, Massachusetts 02445  
(617) 738-3300

**ADULT PATIENT HEALTH PROFILE**

This form is **confidential**. The information cannot and will not be given to anyone outside this clinic without your written permission. Please answer all questions honestly and with the intent of providing as thorough a picture as possible of your **health** history.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F Blood Type: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital/Life Partner Status: \_\_\_\_\_ No. of Children: \_\_\_\_ Ages: \_\_\_\_\_

How did you hear about our center? \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**Present Health Concerns:** Please list your most important health concerns in their order of significance and how long you've had each.

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Are you willing to change your living habits to improve your health? Yes No

What goals do you have for your visit today?

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Have you ever consulted a Naturopathic physician before? Yes No

Name of last doctor consulted: \_\_\_\_\_ Date of last complete check-up: \_\_\_\_\_

**Past Medical History:** Please include date and how you believe this affected you in the past and/or currently.  
Any known problems during your mother's pregnancy with you and/or birth trauma:

Serious illness: \_\_\_\_\_

Medications, esp. if taken for over 2 weeks: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Major accidents: \_\_\_\_\_

Severe stresses/emotional traumas: \_\_\_\_\_

Psychiatric illness: \_\_\_\_\_

For Women-Date of last Pap Smear: \_\_\_\_\_ Were the results? Normal Abnormal \_\_\_\_\_

**Allergies:**

Medications \_\_\_\_\_

Foods \_\_\_\_\_

Environmental \_\_\_\_\_

What Happens when exposed? \_\_\_\_\_

\_\_\_\_\_

**Childhood:** Please list all significant/recurrent illnesses, reactions to vaccinations, major events, stresses from birth through high school.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**Current Medications:** List all prescription/non-prescription items with dosage and duration.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Supplements:** List all vitamins, minerals, herbs, homeopathics with dosage and duration.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you consider your strong points in your health and happiness? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is the area of most concern to you in your life?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Diet:** *Never Occasionally Weekly Daily* The type of diet I usually follow is classified as:

Organic Foods

Red Meat \_\_\_\_\_ How do you feel about your current eating patterns?  
 Fish/Chicken \_\_\_\_\_  
 Fresh Vegetables \_\_\_\_\_ How many glasses of water do you drink each day? \_\_\_\_  
 Dairy Products \_\_\_\_\_ How is your appetite:  
 Fresh Fruits \_\_\_\_\_ \_\_\_Excessive \_\_\_Strong \_\_\_Average \_\_\_Weak \_\_\_Lacking  
 Whole Grains \_\_\_\_\_ How do you classify your Digestion:  
 Sweets \_\_\_\_\_ \_\_\_Good and Strong \_\_\_Average \_\_\_Poor and Weak

**Generals:**

Sleep: How many hours do you typically sleep a night? \_\_\_\_\_ Are you satisfied with your sleep? \_\_\_\_\_  
 Primary Interests and Hobbies: \_\_\_\_\_  
 What Exercises/Activities give you pleasure? \_\_\_\_\_  
 Activity level: \_\_\_ Inactive \_\_\_ Moderately \_\_\_ Very active  
 Overall energy level (today) on a scale of 1 (cannot get out of bed) to 10 (the best you have ever had): \_\_\_\_\_  
 Are you satisfied with the sexual aspect of your life? \_\_\_\_\_  
 Temperature: Generally, are you: \_\_\_chilly \_\_\_always warm \_\_\_average \_\_\_bothered by extremes in temperature

**Family History:** Please identify which family members have had any of the following.

Mother (M)	Father (F)	Brother (B)	Sister (S)	Grandparent (G)	Your Children (C)
Alcoholism		Epilepsy		Kidney Disease	
Allergies		Glaucoma		Mental Illness	
Anemia		Headaches		Nervous Disorder	
Anxiety		Hearing Loss		Skin Rashes	
Arthritis		Heart Attack		Stroke	
Asthma		Heart Disease		Tuberculosis	
Autoimmune		Hepatitis		Venereal Disease	
Cancer		High Blood Pressure			
Diabetes		Hypothyroid			

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