Beacon Naturopathic Health Center

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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.

_____

_____

_____

_____

_____

_____

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

What goals do you have for your visit today?

_____

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._____

_____

_____

_____

_____

_____

_____

_____

_____

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	