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Global Naturopath & GN Health Foods

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Welcome to Global Naturopath……………………………………

Naturopathic Medicine is a form of complementary and alternative medicine, which recognizes the inherent healing capacity within each individual and seeks to stimulate, enhance and support this innate ability in order to achieve optimal health and well being. Global Naturopath offers a patient-centered healing approach. Therefore, the goal is to discover the underlying cause of illness, rather than merely focusing on the patient's symptoms or disease.

At Global Naturopath, a holistic medicine approach is offered which integrates mind and body to restore and maintain balance

Directions for completing Intake form

Carefully look over the History form and plan to fill out each page per day if felt necessary. Make a point to fill the form in as much detail as possible. The more detail the history form, the more the healthcare professional can know about your health.

Feel free to write in the margins or at the back of the questionnaire and to add detailed observations where appropriate.

Don’t be overwhelmed with the form. The information is enclosed, it will be useful in deciding the treatment plan to make you feel healthy and strong.

Note: Please fill the Questionnaire and either email, fax or mail the form a week before you Initial evaluation. Please either attach or bring additional evaluation or medical reports.

Adult Intake Form

Appointment Date ___________________________________
Appointment Time ___________________________________

Patient Profile

Name of Patient ____
Date of birth _______________ (MM/DD/YY) **Social Security #** ___________ **Sex M F**
Address:
____
____

Telephone number: Home: ______________________ **Work:** _________________________

Highest Degree of Education ____

Employer ____

Occupation ____

E-mail Address: ____

May we leave messages relating to your visits? Y N

Emergency contact: Name: ____

Phone number: ___________________ **Relation:** ____________________________________

How did you hear about this Clinic?____

Relationship status

Single: ___________ **Married:** ___________ **Separated:** __________
Divorced: __________ **Domestic Partner:** __________ **Widowed**____________

Live with: (Y or N) **Spouse**___ **Partner**____ **Parents**____
Children___ **Friends**___ **Alone**____

No of Children and ages of children (if applicable):

____ _______________________________

A note to our patients: **Please complete this questionnaire as thoroughly as possible. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you. Please list other health care providers you are seeing:**

1. ____

____

(______)_____________________

2.

____

____

(______)_____________________

3.

____

____

(______)_____________________

Present General Health

Current Weight: ___________________Desired Weight (if different): ____________________
Maximum Weight: _________________When? ____
Minimum Weight: _________________ When? ____
Have you gained or lost any weight in the past 6-12 months? Y N
If yes, how much? ____

If you are female, are you currently pregnant? Yes No (Please circle one)

How would you describe your general state of health (please circle one)?
Excellent Good Fair Poor

Current Health Concerns

Please list in order of importance the health concerns that you would like to address today.

1. ___________________________________ 4.____________________________________
2.___________________________________ 5.____________________________________
3. ___________________________________ 6.____________________________________

What if any treatments have you tried for these conditions and what were the results?
____
____

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with, approximate dates and the reason.
____
____
____
____
____
____
____

Do you have any allergies (medicines, environmental, dietary etc.)?
____
____
____
____

Please list all current medications you are taking or taken in past (including prescription medications, over-the-counter, vitamins, minerals, Herbs, or homeopathic treatments, etc.)

	Name	Dosage	Reason	Benefits seen

Approximately how many times have you been treated with antibiotics and for reasons?

____
____
____
____

Do you consume any of the following at least once a week?

- ☐ Antacids
- ☐ Carbonated drinks
- ☐ Laxatives
- ☐ Salt (in excess)
- ☐ Coffee
- ☐ Caffeine
- ☐ Sedatives
- ☐ Artificial sweeteners
- ☐ Distilled water
- ☐ Luncheon meat
- ☐ Tea
- ☐ Fast foods
- ☐ Recreational drugs
- ☐ Birth control pills
- ☐ Alcohol
- ☐ Fried foods
- ☐ Margarine
- ☐ Tobacco
- ☐ Sweets / candy
- ☐ Steroids
- ☐ Aspirin

How do you relax (include hobbies and leisure activities)?

____
____
____
____
____

How is your energy level? Rate on a scale of 1 to 10 (1=very low; 10=excellent). Any changes felt in last 6 months.

____
____
____
____
____

Do you smoke? Y or N

Have you smoked in the past? Y or N

If you smoke, how many packs per day for how many years?

____

Do you exercise regularly (include frequency, duration, and type)?

Please indicate what immunizations you have had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A
☐ Tetanus booster; date?____________	☐ "Flu"	☐ Hepatitis B
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Smallpox

Other ____
____

Please indicate any adverse reactions in response to any of these vaccines

____
____
____
____

Description about Diet____
____
____
____
____
____
____

Do you have any food allergies or intolerances? Please list.

____
____
____
____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____
____
____
____
____

Describe a typical day's diet

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages (type and amount)	

Personal and Family History **(check "yes" if you have had the condition or Is the condition in current. Also include if a family member had the condition- please list who i.e. Mother, aunt, grandfather, etc.**

Conditions	Relationship to Person	Present state of Person
Allergies		
Asthma		
Heart Disease		
Drug/ Alcoholism		
Colitis Kidney Disease		
Depression		
High Blood Pressure		
Thyroid		
Diabetes		
Obesity		
Arthritis		
Allergies/Hay		
Liver Disease		
Mental Illness		
Cancer		
Colon Cancer		
Breast Cancer		
Stroke		
Scarlet Fever		
Lyme Disease		
Tuberculosis		
Eczema		
Hepatitis		
Anemia		
Mononucleosis		
Influenza		
Shingles		
Mumps		
Measles		
Rubella		
Malaria		
Chicken Pox		
Herpes/Cold Sores		

Conditions	Relationship to Person	Present state of Person
German Measles		
Whooping Cough		
Diphtheria		
Polio		
Encephalitis		
Valley Fever		
HIV		
Epstein-Barr/ CFS		
Candida		
Thrush		
Meningitis		
Blood Transfusion		
Sepsis		
Epilepsy		
Kidney Stones		
Migraine		
Lupus		
Parasites		
Reaction to Vaccines		
Immune System Problems		
ADD/ADHD		
Autism		
PDD-NOS		
Sugar Disorder		
Chronic Fatigue Syndrome		
Food Allergies		
Breast Cancer		
AIDS		
Alzheimer's Disease		
Cholestrol		

Please list any other condition, not included in the list above

____

____

____

Please check off any conditions you currently have or have had in the past

Skin Issues and Problems

Past	Current		Past	Current	
☐	☐	Psoriasis	☐	☐	Eczema
☐	☐	Hives	☐	☐	Rashes
☐	☐	Cradle cap	☐	☐	Bumps on upper arms
☐	☐	Acne on back	☐	☐	Acne on face
☐	☐	Acne on chest	☐	☐	Acne on shoulders
☐	☐	Easy bruising	☐	☐	Dark circles under eyes
☐	☐	Patchy dullness	☐	☐	Thick callousness
☐	☐	Oily skin	☐	☐	Read face hair
☐	☐	Pale skin	☐	☐	Ears got red
☐	☐	Sensitive to bug bites	☐	☐	Itching of scalp
☐	☐	Rash / hives			

Skin in general____

Musculoskeletal Responses

Past	Current		Past	Current	
☐	☐	Calf Cramps	☐	☐	Foot Cramps
☐	☐	Constant Movement	☐	☐	Muscle Twitches around eyes
☐	☐	Muscle twitches in legs	☐	☐	Muscle Twitches Arms
☐	☐	Chest Tightness	☐	☐	Tics
☐	☐	Tension Headaches	☐	☐	Muscle Spasm in Neck,
☐	☐	Muscle Spasm in shoulder/Back	☐	☐	Muscle weakness
☐	☐	Muscle pain	☐	☐	Muscle Stiffness
☐	☐	Muscle Tremor	☐	☐	Touch aversion
☐	☐	Limb Apraxia	☐	☐	Joint and muscle pain
☐	☐	Joint swelling	☐	☐	Atrophy
☐	☐	Rigidity	☐	☐	Trembling
☐	☐	Joint redness	☐	☐	Rolls feet inwards when walking
☐	☐	Recurrent hip dislocation	☐	☐	Recurrent shoulder dislocation
☐	☐	Hypotonia	☐	☐	Short stature

Mood and nerves

Past	Current		Past	Current	
☐	☐	Anxiety	☐	☐	Irritability
☐	☐	Depression	☐	☐	Panic Attacks
☐	☐	Hyperactivity	☐	☐	Phobias
☐	☐	Fearfulness	☐	☐	Sighing
☐	☐	Suicidal Thoughts	☐	☐	Light-headiness
☐	☐	Dizzy (Spin)	☐	☐	Fainting
☐	☐	Seizures	☐	☐	Difficulty concentrating
☐	☐	Difficulty maintaining balance	☐	☐	Difficulty with thinking
☐	☐	Difficulty with Judgment	☐	☐	Difficulty with short term memory
☐	☐	Difficulty with long term memory	☐	☐	Learning Problems
☐	☐	Tingling	☐	☐	Constant eye blinking
☐	☐	Toe walking	☐	☐	Mood Swings

Eyes health

Past	Current		Past	Current	
☐	☐	Conjunctivitis	☐	☐	Eye Pain
☐	☐	Distorted Vision	☐	☐	Eye Crushing
☐	☐	Lid Margins red	☐	☐	Itchiness
☐	☐	Sensitivity to Sunlight	☐	☐	Frequent blinking
☐	☐	Poor eye-hand coordination	☐	☐	Blurred Vision
☐	☐	Watering	☐	☐	Granulated lids
☐	☐	Burning sensation	☐	☐	Puffiness under eyes
☐	☐	Mucous in eyes	☐	☐	Rubbing eyes
☐	☐	Cross eyedness	☐	☐	Dilated pupils
☐	☐	Turns eyes to read/ draw	☐	☐	Poor acuity
☐	☐	Deep set eyes	☐	☐	Loss of lateral eye movement
☐	☐	Wrinkles under eyes	☐	☐	Spots/flashes before eyes
☐	☐	Blood spots in eyes	☐	☐	Dark circle under eyes
☐	☐	Swollen eyes	☐	☐	Dryness in eyes
☐	☐	Development Optometry	☐	☐	Diptopia (double vision)
☐	☐	Swelling between eyebrows	☐	☐	Very long eyelashes
☐	☐	Pupils react sluggishly to light	☐	☐	Squints eyes frequently
☐	☐	Brownish stain on outer iris	☐	☐	Turns head and squints one eye to see
☐	☐	Looks from corner of eyes	☐	☐	Eyes worst from Season Allergies

Ear Health

Past	Current		Past	Current	
☐	☐	Ear Pain	☐	☐	Ear Infections
☐	☐	Ear ringing	☐	☐	Ear Noises
☐	☐	Hearing Loss	☐	☐	Auditory Processing Difficulties
☐	☐	Sensitivity to loud sound	☐	☐	Ear Fullness
☐	☐	Frequent ear infections	☐	☐	Nerve deafness
☐	☐	Sense of imbalance	☐	☐	Pain in ears
☐	☐	Fluid accumulation	☐	☐	Tubes in ears
☐	☐	Eustachian block	☐	☐	Crusting
☐	☐	Uneven skin around ears	☐	☐	Prominent ears
☐	☐	Red ear lobes	☐	☐	Dizziness
☐	☐	Wears hearing aid	☐	☐	Itching inside ears
☐	☐	Drainage	☐	☐	Hearing on/off
☐	☐	Pressure inside ears	☐	☐	Ruptured ear drums
☐	☐	Excessive wax problems	☐	☐	Eczema behind ears
☐	☐	Soft cartilage around ears	☐	☐	Ear problems with seasonal allergies

Gastrointestinal Issues or Problems

Past	Current		Past	Current	
☐	☐	Thrush	☐	☐	Teeth grinding
☐	☐	Bloody gums	☐	☐	Periodontal disorder
☐	☐	Dry mouth	☐	☐	Geographic tongue
☐	☐	Sore tongue	☐	☐	Canker sores
☐	☐	Cold sores	☐	☐	Sore throat
☐	☐	Swollen lymph nodes	☐	☐	Frequent Nausea
☐	☐	Vomiting	☐	☐	Upper abdomen pain
☐	☐	Lower abdomen pain	☐	☐	Bloating of upper abdomen
☐	☐	Bloating: lower abdomen	☐	☐	Burping
☐	☐	Farting	☐	☐	Frequnet Diarrhea
☐	☐	Constipation	☐	☐	Undigested foods in stool
☐	☐	Mucous in stool	☐	☐	Blood in stool
☐	☐	Hemorrhoids	☐	☐	Anal Spasms
☐	☐	Colic	☐	☐	Heartburn
☐	☐	Indigestion	☐	☐	Ulcers
☐	☐	Craves Sweet	☐	☐	Holds back bowel movement
☐	☐	Stool strong bad smell	☐	☐	Bowel more than 3 times per day
☐	☐	Stool is large bulky	☐	☐	Stool is soft and mushy
☐	☐	Stool floats in water toilet	☐	☐	Roughage Intolerance
☐	☐	Vomits protein food only	☐	☐	Rumbling
☐	☐	Excessive flatulence	☐	☐	Vomit of strong smell
☐	☐	Change in appetite	☐	☐	Change in thirst
☐	☐	Food allergies / intolerances			
☐	☐	Gas problems after eating certain foods			

Urinary system Health and Problems

Past	Current		Past	Current	
☐	☐	Urinary frequency	☐	☐	Frequency at night
☐	☐	Sense of urgency	☐	☐	Pain
☐	☐	Blood in urine	☐	☐	Difficulty passing urine
☐	☐	Frequent infections			

Nails Analysis

Past	Current		Past	Current	
☐	☐	Habit of nail biting	☐	☐	Nails are soft
☐	☐	Nails brittle	☐	☐	thickening of finger nails
☐	☐	Thickening of toe nails	☐	☐	fungus foot
☐	☐	Fungus fingers	☐	☐	ridges in nails

Sleeping Pattern

Past	Current		Past	Current	
☐	☐	Tossing and turning	☐	☐	Sleep walking
☐	☐	Talking in Sleep	☐	☐	Awakes at night
☐	☐	Nap during the day	☐	☐	Very early riser
☐	☐	Late riser	☐	☐	Difficulty awakening
☐	☐	Night Terrors	☐	☐	Awakens screaming
☐	☐	Difficulty saying asleep			

Cardiac and Respiratory Health

Past	Current		Past	Current	
☐	☐	Wheezing	☐	☐	Rapid Heartbeat or rate
☐	☐	Asthma	☐	☐	Skipped heart beats
☐	☐	Heart Palpitations	☐	☐	Dry cough problems
☐	☐	Tingling	☐	☐	Croup
☐	☐	Frequent Infections	☐	☐	Chronic Fatigue Syndrome
☐	☐	Tight Chest	☐	☐	Ankle Swelling
☐	☐	Cold hand and feet	☐	☐	Bradycardia
☐	☐	Barky cough	☐	☐	Swollen feet
☐	☐	Frequent coughs	☐	☐	Night sweats
☐	☐	Cough mucous	☐	☐	Shortness of breath (dyspnea)
☐	☐	Bronchitis	☐	☐	Murmurs
☐	☐	Frequent colds	☐	☐	Flushing of skin
☐	☐	Frequent bouts of flu	☐	☐	Stoke or stroke like episodes
☐	☐	Chest pain	☐	☐	Pneumonia
☐	☐	Apnea	☐	☐	Trachea tube
☐	☐	Uneven breathing	☐	☐	Rosy cheeks
☐	☐	Chalky white skin	☐	☐	Lip color pale or colorless
☐	☐	Veins on back of hand are thin			
☐	☐	Veins on back are puffy			
☐	☐	Veins on back are normal			
☐	☐	Breathlessness on slight exertion			

Mouth and Throat

Past	Current		Past	Current	
☐	☐	Headaches	☐	☐	Dizziness
☐	☐	Frequent sore throats	☐	☐	Sore tongue/mouth /gums
☐	☐	Chronic bad breathe	☐	☐	Nosebleeds
☐	☐	Swollen glands	☐	☐	Frequent Nasal congestion
☐	☐	Frequent nasal discharge	☐	☐	Dental cavities - silver fillings
☐	☐	Snores	☐	☐	Throat closes problems
☐	☐	Sleep with mouth open	☐	☐	Canker Sores
☐	☐	Loses Voice	☐	☐	Lips swell
☐	☐	Lips cracks/corners	☐	☐	Difficulty swallowing
☐	☐	Sore Throat	☐	☐	Fever blisters
☐	☐	Gags easily	☐	☐	Crakes in tongue
☐	☐	Bleeding gums	☐	☐	Purple or magnet tongue
☐	☐	Drooling	☐	☐	Abnormal eruptions of teeth
☐	☐	Glossy, shiny tongue	☐	☐	Enlarged tonsils
☐	☐	Teeth appear small allover	☐	☐	Cold sores
☐	☐	Swollen tongue	☐	☐	Grind teethes
☐	☐	Throat palate itches	☐	☐	Chapped lips
☐	☐	Metallic taste in mouth	☐	☐	High Palate
☐	☐	Thin upper lips	☐	☐	Poor sense of taste
☐	☐	Teeth fall out prematurely	☐	☐	Spare amount of taste buds
☐	☐	Chocks easily with liquids			

Other throat or mouth problems

____

____

Female

Age of first period? ____________

Length of full cycle? __________

☐Premenstrual symptoms
☐Painful periods
☐Infertility
☐Frequent vaginal infections
☐Discharge
☐Breast lumps / tenderness
☐Pregnancies # _________
☐Miscarriages #__________
☐Abortions #__________
☐Abnormal Pap tests
☐Sexually transmitted diseases
☐Birth control (if so, what type?) ____
☐Sexual difficulties / difficulties with libido
☐Other gynecological concerns? _________________________
☐ Are you currently sexually active with men, women or both? (circle)

Male

☐Infertility
☐Sexual difficulties / difficulties with libido
☐Sexually transmitted diseases
☐Discharge
☐Rashes
☐Pain in genitals
☐Varicose veins in scrotum
☐Difficulty starting or stopping urine flow?
☐Are you sexually active with men, women or both? (circle)
☐Lumps or masses in testicles

Are you exposed to significant tobacco smoke (work, home, etc.)? Y N

Are you frequently exposed to animals (work, pets, etc.)? Y N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?
Please describe. ____
____

Please describe the emotional climate of your home? (Whom you live with & Relationships)
____
____
____

Please approximate the level of daily stress you experience on a scale of 1-10? How well do you believe you handle these stresses? ____
____
____

Is there anything that you feel is important that has not been covered?
____
____
____
____
____
____