

Health Profile All information is confidential. Please fill out as thoroughly as possible. Holistic health care is most effective when the doctor has an in-depth understanding of your health history & goals on multiple levels. **Please set aside at least 30 minutes to fill out this form.** Your honesty and thoughtfulness will greatly assist me in helping you. Please put a question mark next to any questions you are unsure about. Thank you very much for your time!

Name _____ Date of Birth _____ Today's Date _____

General Information

What are your primary health concerns/reasons for visit?	If applicable, please list prior approaches related to your concerns:		
	Prior diagnoses	Prior labs/imaging	Prior treatments

What expectations do you have of your **first visit** experience?

What **long-term** expectations do you have from working with me?

To what extent are you open to changes in lifestyle habits to address your concerns? *Please circle.* (least open) **1 2 3 4 5** (most open)

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? *Please list.*

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive? *Please list.*

Were there any life events in the 6 mos-1yr prior to you feeling unwell or to your onset of symptoms? Mention anything, even if it seems insignificant (e.g. changing jobs, moving, death in family, etc.)

Do you have any idea of what triggered or is causing your current symptoms?

Are you familiar with a naturopathic approach or have you ever seen an ND, chiropractor, acupuncturist, or other alternative provider?

If there are specific wellness therapies/programs you interested in, please check them here:

- Nutritional counseling
 Herbal Medicine
 Homeopathy
 Exercise therapy
 Detoxification Program
 4 Seasons Program
 Disease prevention
 Preconception Care
 Emotional wellness
 Weight loss program
 Other

What are your supplement type preferences? (*✓ all that apply and cross out those you are definitely not interested in*)

- No preference
 Powder
 Liquid
 Capsule/Tablet
 Tea
 Tincture (alcohol based)
 I have difficulty taking supplements

CURRENT PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS, & SUPPLEMENTS (additional room on pg.5 if needed)

Name (Include brand for supplements)	Dose&Frequency (ex. 500mg 3x/day)	Start date (approximate)	Reason for taking	Has it helped?	Who prescribed? (self or Dr. name)

Don't forget to include topical treatments, herbs, homeopathics & commonly used things like aspirin, antacids, pain-relievers, multivitamins.

Have you used any of the following for an extended period? Circle. Antibiotics Cortisone/Steroids Hormones

List all **allergies/sensitivities** & reaction (even if minor reaction) For ex: peanuts→trouble breathing or dairy→stuffy nose

Drug/Supplement _____ Environment (pollens, etc) _____

Food _____

Did you have vaccinations as a child? Yes No As an adult? Yes No Any adverse reactions? Yes No Maybe/?

List and date all surgeries, hospitalizations, major injuries/illnesses (*don't forget tonsil/gallbladder/appendix removal & hysterectomy*):

Please list major childhood illnesses with approximate age (*don't forget chronic/frequent infections i.e. strep throat, earaches, mono*):

Check EXAMS, LABS, IMAGING which you have received, indicate date of most recent, and check if normal results or not:

Check if you have received	√	Date	Normal Results?	Check if you have received	√	Date	Normal Results?
Physical Exam	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	EKG/ECG (heart study)	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Cholesterol check	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Mammogram ♀	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood sugar check	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Pap Smear ♀	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Colonoscopy/sigmoidoscopy	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Check ♂ (DRE, PSA)	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Fecal Occult Blood (√s for blood in stool)	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	CT Scan/MRI for: _____	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone Density Scan(DEXA)	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	X-ray for: _____	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
STD/HIV Screen	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Ultrasound for: _____	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History

Condition	Self	Father	Mother	Sibling1	Sibling2	Grandmother (maternal)	Grandfather (maternal)	Grandmother (paternal)	Grandfather (paternal)
Age if living	N/A								
Age at death	N/A								
Cause of death	N/A								
√ box if applicable.									
Alcohol/Drug Addiction									
Alzheimer's									
Asthma/Allergies									
Autoimmune Disease									
Cancer (specify type)									
Celiac Disease									
Colitis/Crohn's									
Depression									
Diabetes									
Heart disease									
High blood pressure									
High cholesterol									
Mental illness(specify)									
Stroke									
Thyroid problems									
Other (specify)									

Review of Systems

Please circle as follows: (Y)=Yes, I currently have this problem (P)=I have had this in the past*

*For past problems, only circle if significant. Ex: everyone has had a cough due to a cold, so you don't need to circle this unless it was a recurrent/significant problem.

Current weight: Maximum weight: Height: Are you content with your weight?

<u>General</u> ♦		<u>Respiratory</u> ♦		<u>Urinary</u> ♦		<u>Musculoskeletal</u> ♦	
Fatigue	Y P	Cough	Y P	Pain on urination	Y P	Joint pain/stiffness	Y P
Night Sweats	Y P	Sputum	Y P	Increased urgency	Y P	Muscle pain	Y P
Sweats/perspire easily	Y P	Spitting up blood	Y P	Increased frequency	Y P	Muscle spasm/cramps	Y P
Fever/Chills	Y P	Wheezing	Y P	Blood in urine	Y P	Weakness	Y P
Headaches	Y P	Shortness of breath	Y P	Wake to urinate	Y P	Back problems	Y P
Loss of/change in appetite	Y P	-with exertion	Y P	Inability to hold urine	Y P	Trauma/swelling	Y P
Sensitive:		-lying down	Y P	Bladder infection/UTI	Y P	Arthritis	Y P
-to smells/chemicals	Y P	Pain on breathing	Y P	Kidney disease	Y P	Osteoporosis	Y P
-to light/noise	Y P	Bronchitis/Pneumonia	Y P	Kidney stones	Y P	Restless/jittery legs	Y P
-to alcohol/meds	Y P	Emphysema	Y P	Pelvic pain	Y P	<u>Neurologic</u> ♦	
Unintentional		Tuberculosis	Y P	<u>Female Reproductive</u> ♀		Fainting	Y P
weight loss/gain	Y P	Asthma	Y P	Are you pregnant or lactating?	Y N	Seizures/epilepsy	Y P
Chronic fatigue syndrome	Y P	Practice deep breathing?	Y N	Age menses began: _____		Dizziness/vertigo	Y P
Fibromyalgia	Y P	<u>Cardiovascular</u> ♦		Date of last period: _____		-when standing up	Y P
<u>Skin, Hair, Nails</u> ♦		Palpitations/flutter	Y P	# of days period lasts: _____		Numbness/tingling	Y P
Dry skin	Y P	Chest tightness	Y P	Cycle length (e.g.28d): _____		Loss of memory	Y P
Rashes/itching	Y P	Chest pain/angina	Y P	Are your cycles regular?	Y N	Problems walking	Y P
Acne, boils	Y P	High blood pressure	Y P	Heavy flow	Y P	Head injury/concussion	Y P
Slow wound healing	Y P	Low blood pressure	Y P	Diminished flow	Y P		
Hives	Y P	High cholesterol	Y P	Large clots	Y P	<u>Endocrine</u> ♦	
Warts	Y P	Heart murmur	Y P	Painful menses/cramps	Y P	Cold/heat intolerance	Y P
Hair loss	Y P	Swelling of hands/feet/legs	Y P	Bleeding b/t periods	Y P	Difficult to ↑ weight	Y P
Dry, brittle hair/nails	Y P	Cold hands/feet	Y P	Facial hair growth	Y P	Difficult to ↓ weight	Y P
Dandruff/flaky scalp	Y P	Varicose veins	Y P	PMS	Y P	Excessive thirst	Y P
White spots on nails	Y P	Deep leg pain	Y P	Describe:		Excessive hunger	Y P
Deep ridges on nails	Y P	Deep vein thrombosis	Y P	Menopause symptoms	Y P	Hypoglycemic	Y P
Psoriasis	Y P	Rheumatic fever	Y P	Describe:		Diabetes/pre-diabetes	Y P
Eczema	Y P	Stroke	Y P	Age at menopause: _____		Hypothyroid	Y P
<u>Ears/Eyes</u> ♦		Heart Disease	Y P			Hyperthyroid	Y P
Corrective lenses	Y P	<u>Gastrointestinal</u> ♦		# of Pregnancies: _____		Cushings or Addison's	Y P
Impaired/double vision	Y P	Nausea	Y P	Breast pain/tenderness	Y P	<u>Immune/Blood</u> ♦	
Dry eyes/tearing	Y P	Vomiting	Y P	Breast lumps	Y P	Anemia	Y P
Eye pain	Y P	Bloating	Y P	Nipple discharge	Y P	Easy bleeding/bruising	Y P
Poor night vision	Y P	Flatulence(gas)	Y P	Yeast/vaginal infections	Y P	Chronic/frequent infection	Y P
Dark circles under eyes	Y P	Belching	Y P	Endometriosis	Y P	Seasonal allergies/hayfever	Y P
Earaches/infections	Y P	Abdominal pain	Y P	Polycystic ovaries	Y P	Frequent infection as child	Y N
Ringling in ears	Y P	Heartburn/GERD	Y P	# of Live Births: _____		Swollen glands/nodes	Y P
Hearing loss	Y P	Trouble swallowing	Y P	# Miscarriages/Stillbirths: _____		History of tick bites	Y P
Excessive ear wax	Y P	Jaundice (yellow skin)	Y P	Difficulty conceiving	Y P	Breastfed as baby?	Y N
<u>Nose and Sinuses</u> ♦		Liver disease	Y P	Future OB plans	Y N ?	Epstein Barr virus	Y P
Sinus problems	Y P	Gallbladder stones/attack	Y P	Sexually active?	Y P	Mononucleosis	Y P
Post nasal drip	Y P	Ulcer	Y P	Practice safer sex?	Y N	Helicobacter pylori	Y P
Stuffiness	Y P	Anal pain/itching	Y P	Sexual difficulties	Y P	HIV/AIDS	Y P
Nose bleeds	Y P	Hemorrhoids	Y P	STDs	Y P	<u>Other</u> ♦	
<u>Mouth and Throat</u> ♦		Laxative use	Y P	<u>Male Reproductive</u> ♂		Mental fog	Y P
Frequent sore throat	Y P	<u>Bowel Movements</u> ♦		Testicular masses/swelling	Y P	Panic attacks	Y P
Sore tongue	Y P	How often? _____		Testicular pain	Y P	Mood swings	Y P
Coated, white tongue	Y P	Loose stool/diarrhea	Y P	Prostate problems	Y P	Alcoholism	Y P
Canker sores	Y P	Constipation	Y P	Hernias	Y P	Drug dependency	Y P
Cold sores	Y P	Blood in stool	Y P	Discharge or sores	Y P	Eating disorder	Y P
Gum problems	Y P	Mucus in stool	Y P	Sexually active?	Y P	Alzheimer's/dementia	Y P
Bitter/strange taste	Y P	Undigested food in stool	Y P	Practice safer safe?	Y N	Attention deficit	Y P
Dental cavities	Y	Black stool	Y P	Sexual difficulties	Y P	Depression	Y P
# of amalgam fillings: _____		Straining or pain w/BM	Y P	STDs	Y P	Seasonal depression	Y P
Root canals	Y	Greasy/fatty stool	Y P				

Diet and Lifestyle

Please circle # corresponding to use: ~~0~~never ~~1~~seldom (4x/month or less) ~~2~~moderate (1-4/week) ~~3~~frequent (5-7x/week)

Coffee	0 1 2 3	Fruit	0 1 2 3	Soy (tofu, milk, etc.)	0 1 2 3
Tea (type:)	0 1 2 3	Vegetables	0 1 2 3	Fish/Seafood	0 1 2 3
Soda	0 1 2 3	Beans/legumes	0 1 2 3	Poultry	0 1 2 3
Alcohol	0 1 2 3	Nuts/seeds	0 1 2 3	Red Meat	0 1 2 3
Fruit Juice	0 1 2 3	White flour products	0 1 2 3	Eggs	0 1 2 3
Snack foods (chips, etc)	0 1 2 3	Whole grains	0 1 2 3	Seaweeds	0 1 2 3
Sweets (desserts/candy)	0 1 2 3	Potatoes	0 1 2 3		
Fast food	0 1 2 3	Brown/white rice	0 1 2 3	Cigarettes/Tobacco	0 1 2 3
Artificial sweeteners*	0 1 2 3	Milk/cheese/cream	0 1 2 3	# of cigs/day For how long?	
Water	cups/oz per/day	Yogurt	0 1 2 3	Recreational drugs	0 1 2 3

*Includes aspartame/nutrasweet/sorbitol/sucralose/Splenda found in diet sodas, candy, and used in beverages for sweetening

Do you follow any specific type of diet? If so, please describe? (include foods avoided like gluten or dairy, "named" diets like Atkin's, vegetarian/vegan, whole foods diet, etc.)

Please list a typical breakfast, lunch, dinner, and snack for you:

Breakfast	
Lunch	
Dinner	
Snack	

List any food cravings _____

Average hours of sleep/night? _____ Normal Bedtime _____ Normal waking time _____

<i>Please check those that apply:</i>	◇Sensitive sleeper, wake easily	◇Pain or physical disorder prevents sleep
◇Trouble falling asleep initially	◇Grinding teeth	◇Reflux/heartburn while in bed
◇Can't fall back to sleep if I wake up	◇Snoring/gasping for air	◇Wake unrefreshed/irritable
◇Frequent waking in night ◇to urinate	◇Excessive dreaming	◇Waking too early in AM
◇Racing thoughts preventing sleep	◇Can't remember dreams	◇Sleepy during day

Rate your stress level. Circle. 1 2 3 4 5 (most stress) What do you do to relieve stress? _____

Frequency of exercise per week? ◇Never ◇1-3x/week ◇3-5x/week ◇5-7x/week Other: _____

What types of exercise? (for ex: elliptical, skiing, weight training, etc.) _____

Do you have trouble getting enough exercise or sticking to a routine? _____

Rate your energy level. Circle 1 2 3 4 5 (most energy) My energy is best in: ◇Morning ◇Afternoon ◇Evening/Night

My energy is worst in: ◇Morning ◇Afternoon ◇Evening/Night

Environment

Have you had any toxic environmental exposures in your lifetime? ◇Yes ◇No ◇Maybe

Explain.

Are you exposed to any toxins or chemicals in your hobbies/work on a frequent basis? (pesticides w/gardening, lead solder, etc) ◇Yes ◇No

Explain.

How often do you buy organic produce and products? Circle. Never Sometimes Often Always

How often do you buy hormone free, antibiotic free animal products? Circle. Never Sometimes Often Always

Have you ever had problems with mold at work or at home? ◇Yes ◇No

Have you ever lived in a house with brand new carpet, new furniture, or during or following a remodel? ◇Yes ◇No

Work and Social History

Are you: Single Married Partnered Separated Divorced Other

Who do you live with: Alone Partner/Spouse Relatives Friends Kids Other

Do you feel safe in your living environments? (home, work, school) Yes No

Do you have children? If yes, please list names and ages _____

Are you content with your relationships & support system? Who do you turn to for support?

What do you do for work? _____

How do you feel about your work/career? _____ # of hours you work per week? _____

Have you ever traveled outside the U.S.? If so, where? _____

How much time do you spend outside in a week? _____ Hobbies/Interests _____

Please check any of the following emotions that have **predominated** lately:

- joyful peaceful excited motivated sad stressed angry hurt abandoned bored worried irritable
grieving depressed unmotivated fearful anxious trauma-related stress abuse-related stress other:

What brings you joy in life?

What are your current challenges/frustrations in life?

If there is anything else you would like me to know about you and your health, please use the space below:

Thank you for your time! Once completed, please do one of the following:

- mail to PO Box 579, Driggs, ID 83422 (if appt is at least 2 days away if you live in the area)
- fax to 208.354.9578
- scan document and email to chante@pangeanaturalhealth.com
- drop off at my office at 65 S. Main St. Suite 6 in Driggs (upstairs in Blackhawk building above Teton County Title; you can slide it under the door if I am unavailable)

By reviewing ahead of time, I will be able to make the most of your first visit. If unable to do so, please bring with you to your first visit, along with any copies of recent lab reports, and bottles of supplements you are currently taking.