**CONFIDENTIAL HEALTH QUESTIONNAIRE-NATUROPATHIC**

In making your appointment you have implied that you are ready to make some changes in your life to experience better health. Taking your precious time to fill out this questionnaire will help me to understand what your goals and expectations are. Together we will formulate a health care plan that will work for you. I am the only person who reviews these forms. If you are uncomfortable answering any of the questions, just leave them blank and we will discuss them during your first visit. When filling out the forms, please use the back of the page if you need more room and let me know if there are specific treatments you have in mind or need more information about them. I sincerely thank you for sharing your important information with me and I look forward to seeing you at your appointment.

To Your Health,

Dr. Coleen Murphy ND

**Personal Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  |  | Date | \_\_\_\_\_\_/\_\_\_\_\_\_\_/20\_\_\_ | |
|  |  |  |  |  | |
| Address |  |  | Gender | \_\_\_Male \_\_\_Female | |
|  |  |  |  |  | |
| City, State  Zip | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Height | \_\_\_ Feet \_\_\_ Inches | |
|  |  |  | Date of Birth | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ | |
| Phone-Cell |  |  |  |  | |
|  |  |  | Weight \_\_\_\_\_\_ pounds | |  | |
| Phone-Home/  Business |  |  |  |  | |
| Occupation |  |  | Name of Partner/Spouse |  | |
|  |  |  |  |  | |

Hours Worked Per Week \_\_\_\_\_\_\_ hours

# of People Living in your Home \_\_\_\_\_\_\_\_\_\_

Best Number to Leave a Confidential Message: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status: Single / Married / Partnered / Divorced / Widow

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | |  |  |  |
| **Emergency Contact** | |  |  |  |  |
|  |  | |  | Number of Children |  |
| Name |  | |  |  |
|  |  | |  |  |  |
| Relationship |  | |  | Blood type |  |
|  |  | |  |  |  |
| Phone-Home/Cell | ( ) - | |  |  |  |
|  |  | |  | How did you hear about us? |  |
| Phone-Alternate | ( ) - | |  |  |

Please list your 5 major health concerns-

1.

2.

3.

4.

5.

What do you hope to accomplish in your first appointment?

List all Allergies and Sensitivities (drugs, food, environmental, chemical):

List all current medications that you currently take, include dosage(s) and frequency:

List all dietary supplements, herbs and over the counter medications you are currently taking, include dosage(s) and frequency:

List all medical diagnosis:

List all surgeries, hospitalizations, major accidents, x-rays and special procedures:

**Family Medical History**

Please list if any of your family members has any of these medical problems: type of cancer, diabetes, heart disease, high blood pressure, stroke, epilepsy, mental illness, asthma, allergies, arthritis, eating disorder, drug +/or alcohol abuse, kidney or thyroid problems.

|  |  |
| --- | --- |
| Mother | Father |
| Sister(s) | Brother(s) |
| Mom's mom | Dad's dad |
| Mom's dad | Dad's mom |
| Aunt(s)/ Uncle(s) | |
| Spouse/ Partner | |

**Personal Health Habits**

Do you Exercise? Yes No If yes, Type of Exercise and Frequency?

Do you enjoy your work? Yes no

Do you take vacations? Yes No If yes, How many weeks per year? \_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies?

How much time do you spend outdoors?

Please list supportive relationships:

# Hours spent watching TV: \_\_\_\_\_\_\_\_\_/week, Reading \_\_\_\_\_\_\_ Hours/ Week

Computer \_\_\_\_\_\_\_\_/ day

**Typical Daily Food Intake**

|  |  |
| --- | --- |
| Breakfast: | Lunch: |
| Dinner: | Snacks: |
| Drinks: Coffee: \_\_\_\_\_\_\_\_\_\_\_\_\_cups/day  Tea: \_\_\_\_\_\_\_\_\_\_\_\_\_cups/day  Water: \_\_\_\_\_\_\_\_\_\_\_\_\_cups/day  Please Circle or Bold: Distilled, Tap or Well Water | Foods you avoid: |

Please Circle or **Bold** if you avoid these things or if you have them less than 2 times a month:

Alcohol, Artificial sweeteners, Candy, Desserts, Sugar, Carbonated beverages,

Chewing tobacco, Cigarettes, Cigars/pipes, Caffeinated beverages, Fast foods, Fried foods, Luncheon meats, Margarine, Dairy products, Refined flour, Baked Goods,

Diet for weight control, Corn syrup, Recreational drugs

**Stress Level**

Please list the most significant, stressful events in your life, from the most recent to the most distant.

1.

2.

3.

4.

Are any of these events continuing to impact your life? Please Indicate with a \*

Has there been a trauma or sickness that you felt you have never recovered from and you have not been well since? Please explain:

Do you have any history of abuse or trauma?

Have you recently changed job or job duties?

Recent change in romantic relationship?

Unhappy with romantic life?

Do you have a spiritual practice?

**MEDICAL HISTORY**: Please check only those that pertain to YOU personally.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NOW** | **PAST** | CONDITION | **NOW** | **PAST** | **CONDITION** |
|  |  | Allergies |  |  | Alcohol Abuse |
|  |  | Arthritis |  |  | Anemia |
|  |  | Bladder / Urinary Problems |  |  | Asthma |
|  |  | Stroke |  |  | Bleeding Problems |
|  |  | Colitis |  |  | Cancer |
|  |  | Diabetes |  |  | Digestive Disturbances |
|  |  | Ear Problems |  |  | Epilepsy |
|  |  | Edema |  |  | Eating Disorders |
|  |  | Eye Problems |  |  |  |
|  |  | Blood Pressure Problem |  |  | Fatigue, Chronic |
|  |  | Fever |  |  | Gum / Teeth Problems |
|  |  | Gall Bladder problems/ removal |  |  | Headaches |
|  |  | Ulcer |  |  | Head Injury |
|  |  | Liver Problems/ Hepatitis |  |  | Heart Disorders |
|  |  | Jaundice |  |  | Hypoglycemia |
|  |  | Kidney Problems/ Stones |  |  | Lung Problems |
|  |  | Mononucleosis |  |  | Psycho-Emotional Difficulties |
|  |  | Exposure to Toxic Substances |  |  | Sexually Transmitted Diseases |
|  |  | Skin Problems |  |  | Thyroid Problems |
|  |  | Hemorrhoids |  |  | Night sweats |

**CHILDHOOD**

Health as a child? (illness, hospitalizations)

Temperament/Emotions as a child?

Breastfed?

Vaccinations?

**Review of Systems**

Which organ system do you feel is your weakest? Your strongest?

**KIDNEY/ BLADDER** Circle or Bold all that apply:

Urine: Cloudy, Bloody, Dark, Strong odor; Burning, Painful, Increase frequency,

Inability to hold urine, Frequent infections, Pain in mid-back region

How many times during the night do you need to urinate?

Anything else?

**HEAD EYES EARS NOSE THROAT MOUTH SKIN NECK** Circle or **Bold** all that apply:

HEAD: Head injury, Migraines, Hair loss, Hair color change, Dizziness, Excessive hair loss and/or coarse hair, Loss of lateral 1/3 of eyebrow, Dandruff

HEADACHES: Please describe when they are better or worse, and location :

EYES: Spots in vision, Spots on iris, Cataracts, Double vision, Impaired vision, Glasses, Contacts, Blurring, Pain, Strain, Color blindness, Tearing, Dryness, Glaucoma, Tendency to need sunglasses, Dark circles under eyes, Puffy around eyes, Whites of eyes not clear,

Poor night vision

EARS: Impaired hearing, Ringing, Earaches

NOSE AND SINUSES: Nose bleeds, Stuffiness, Hay fever, Sinus problems, Loss of smell

MOUTH AND THROAT: Frequent sore throat, Copious saliva, Dry mouth, Teeth grinding,

Teeth clenched, Sore tongue, Thick tongue coat, Sore lips, Gum sensitive, Gum Bleeding,

Hoarseness, TMJ problems, Jaw clicks, Loss of taste, Difficulty swallowing, Lump in throat, Bitter taste in mouth, Bad breath, Corners of mouth cracked, Trouble swallowing

DENTAL HEALTH: How many mercury amalgam fillings?\_\_\_\_\_\_\_ Root canals? \_\_\_\_\_\_\_

Any problems ever since you have had dental work? Yes No

SKIN: Rashes, Eczema, Hives, Acne, Boils, Itching, Lumps, Edema, Dry, Peeling,

Sweat has strong odor, Perspires easily, Easily chaffed, Warts, Bumps on the back of arms,

NAILS: Weak, Brittle, White spots, Fungus infection

NECK: Lumps, Swollen glands, Goiter, Pain, Stiffness

Anything else?

**IMMUNOLOGY**

How many times each year do you get a cold, flu or bronchitis? \_\_\_\_\_\_\_\_

How many days are you sick with it? \_\_\_\_\_\_\_\_\_\_

Do you miss work because of it? Yes No

How many times have you had antibiotics in your life?\_\_\_\_\_\_\_\_\_\_\_

Past reaction to vaccinations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNOLOGY-Continued**

Circle or **Bold** all that apply: Chronically swollen glands, Slow wound healing, Runny/ drippy nose, Frequent colds, Catch colds at the beginning of winter, Mucus producing cough, Never get sick, Allergies, Hives, Night sweats, Fever, Fungus infections

History of: Epstein Bar Virus, Mononucleosis, Herpes Simplex 1 +/or 2, Shingles,

Chronic Fatigue, Hepatitis, Cancer Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else?

**WOMAN'S HEALTH**

Age of first menses? \_\_\_\_\_\_\_\_\_\_\_ Are cycles regular? Yes No Heavy or Light flow?

Age of last menses? (if menopausal) \_\_\_\_\_\_\_\_\_

List menopausal symptoms:

Length of cycle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days, Duration \_\_\_\_\_\_\_\_\_\_\_\_ days

Bleeding between cycles? Yes No Clotting? Yes No

Describe unusual discharge \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last PAP smear date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active? Yes No

Are you currently pregnant? Yes No Not Sure

Date of last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Birth Control Preferred \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If history of Birth Control Pill use, how many years? \_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Pregnancies \_\_\_\_\_\_\_ Live births \_\_\_\_\_\_\_ Miscarriages \_\_\_\_\_\_\_ Abortions \_\_\_\_\_\_\_

Difficulty conceiving? Yes No

Do you do breast self exams? Yes No

Sexual difficulties? Yes No

Circle or **Bold** all that apply: Depression during periods, Mood swings associated with periods (PMS), Crave chocolate around periods, Excess facial or body hair, Hot flashes, Night sweats, Thinning skin

BREAST: Tenderness, Pain, Fibroids, Benign masses, Lumps, Nipple discharge

PELVIS: Endometriosis, Uterine fibroids, Painful intercourse, Vaginal discharge, Vaginal dryness, Vaginal itchiness, Ovarian cysts, Painful menses

History of Sexually Transmitted Diseases: Gonorrhea, Herpes, Abnormal PAP, Chlamydia, Cervical dysplasia, Warts, Syphilis, HPV

Anything else?

**MEN'S HEALTH** Circle or **Bold** all that apply

Sexually transmitted infections: Chlamydia, Warts, Syphilis, Herpes, Gonorrhea, HPV

Discharge, Sores in genital area, Testicular masses, Testicular pain, Decreased sexual function, Premature ejaculation, Impotence**,** Prostate disease, Pain on inside of legs or heels, Hernias

Urination: Difficult to start and stop urine stream, Dribbling, Stream interrupted

Are you sexually active? Yes No

Anything else?

**CARDIOVASCULAR/ BLOOD** Circle or **Bold** all that apply

Heart disease, Angina, Murmurs, Dull chest pain, Palpitations, Fluttering, Tightness in the chest,

Pain that radiates to the arm, Pain worse with exertion, History of Rheumatic fever,

Congestive Heart Failure, Ankles swell, Swelling worse in the evening, Cough at night, Face turns red/ blushes for no reason, Muscle cramps with exertion, Fainting, Hemorrhoids, Dizzy when standing up, High/Low blood pressure, Blood clots, Phlebitis, Easy bleeding, Easy bruising, Anemia, Deep leg pain, Cold hands/feet, Varicose veins, Thrombophlebitis,

Tend to be keyed up, Blood pressure above 120/80, Trouble calming down, Heart races, Heart beats slow, Hears heart beat on pillow at night.

Anything else?

**MUSCULOSKELETAL** Circle or **Bold** all that apply

Joint pain, Morning stiffness, Joint swelling, Stress fracture, Bone loss, Bone spurs,

Tendency to sprain ankles or "shin splints", Very sore after exercise, Muscle spasms, Muscle cramps, Sciatica, Weakness, Carpal tunnel, Paralysis, Limbs feel heavy, Pain on the medial or inner side of the knee, Pain between shoulder blades, Pain on outer thighs, Chronic low back pain, Worse with fatigue, Herniated disk, Bursitis, Tendonitis, Difficulty maintaining manipulative correction, Pain after manipulative correction, Numbness: arms/ legs, Tingling: arms/ legs

Any area of chronic pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What joints? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent broken bones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else?

**MENTAL EMOTIONAL** Circle or **Bold** all that apply

Depression, Mood swings, Anxiety, Nervousness, Tension, Poor concentration, Memory problems, Seizures, Vertigo, Loss of balance, Trouble working under pressure, Seasonal sadness, Mentally sluggish, Feeling spacey, Fear of impending doom, insecure

Considers suicide: Yes Now In the past No

Attempted suicide: Yes No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else?

**RESPIRATORY** Circle or **Bold** all that apply

Cough, Sputum, Spitting up blood, Pain on breathing, Aware of heavy/ irregular breathing, Discomfort at high altitudes, "Air hunger" , Sigh frequently, Compelled to open windows in a closed room, Wheezing, Shortness of breath: with slight exertion, while lying down, in the evening

Have you been diagnosed with: Tuberculosis, Asthma, Bronchitis, Pleurisy, Emphysema, Pneumonia,

Anything else?

**ENDOCRINE** Please Circle or **Bold** all that apply

ADRENAL GLAND: Feeling jittery after drinking coffee, Calm on the outside troubled on the inside

On a scale of 1 to 10 with 10 being the highest, please rate your average STRESS level:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1 to 10 with 10 being the highest, please rate your average ENERGY level:\_\_\_\_\_\_\_\_\_\_\_\_\_

When is your energy the best (time) \_\_\_\_\_\_\_\_\_ the worst \_\_\_\_\_\_\_\_\_\_\_

THYROID GLAND: Sensitive/allergic to iodine, Inward trembling, Flush easily, Fast pulse at rest, Intolerance to high temperatures, Intolerant to cold temperatures

SLEEP: Number of Hours Sleeping/ Night \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Circle or Bold: Wake refreshed, Vivid dreams, Nightmares, Don't remember dreams,

Awake a few hours after falling asleep, Hard to get back to sleep, A "night person",

Difficulty falling asleep, Slow starter in the morning, Easily fatigued, Afternoon yawning, Drowsy, Jerking while falling asleep, Restless leg while sleeping

Anything else?

**GASTROINTESTINAL-**Circle or **Bold** all that apply:

Floating, Sinking, Undigested food, Odor, Mucous, Blood, Loose, Pellet size, Diarrhea,

Constipation, Pain, Cramps, Clay colored stools, Black tarry stools, Feeling of incomplete bowel evacuation, Anus itching

Have you ever had parasites that you know of? Yes No

Have you ever traveled to a third world country, if so for how long? Yes \_\_\_\_\_\_\_\_\_ No

Describe your bowel function: How often \_\_\_\_\_\_\_\_\_\_.

CRAVINGS: Sweets, Coffee, Sugar, Binge eating, Fats, Grease, Bread, Noodles, Salt, Chocolate, Excessive thirst, Excessive hunger

SENSITIVITY: Headache if meals are skipped or delayed, Shaky if meals delayed, Heartburn, Stomach upset by taking vitamins, Wheat or grain sensitivity, Dairy sensitivity, Pulse speeds after eating, MSG reaction

Food allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific foods make you tired or bloated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOOD RELATIONSHIPS: Irritable before meals, Fatigue that is relieved by eating,

Sleepy after meals, Loss of appetite, Loss of thirst, Feel like skipping breakfast, Bloating within one hour after eating, Sense of excess fullness after meals, Feel better if you don’t eat, Become sick when drinking alcohol, Easily intoxicated when drinking alcohol, Abdominal bloating 1 to 2 hours after eating, Pain or cramping: Stomach, Under the rib cage, Lower abdominal region

Belching or passing gas \_\_\_\_\_\_\_\_\_\_\_\_ (how many minutes/ hours) after eating

PREVIOUS DIAGNOSIS: Ulcerative colitis, Crohn's disease

Weight: Difficulty losing weight , Difficulty gaining weight

Nausea with: morning sickness, tobacco smoke, diesel fumes, greasy foods, motion sickness, alcohol, unknown association

Vomiting: How often \_\_\_\_\_\_\_\_\_\_\_\_\_ With Blood? Yes No

Anything else?

**HEALTH COMMITMENT** Please answer these question either in the space provided or on the back of the page. Thank you

1. What do you believe to be the key areas that you must effectively address in order to access more of your healing potential?

What current behavior and lifestyle habits do you believe you need to change to benefit your

health? i.e. diet, rest, relaxation, creative expression, occupation, addictive behaviors etc.

2. Which of these areas is the single most important one to be addressed right now?

3. What behavior or lifestyle habits do you currently engage in regularly that you believe support your health?

4. Do you consider yourself currently to be proactive with respect to your health and in what ways?

a) If no, have you ever been and if so why did you stop?

5. What do you perceive YOUR role or responsibility is with respect to your healthcare?

6. What do you perceive as MY responsibility with respect to your healthcare?

i.e. How can I best assist you in attaining better health?

7. What is your present level of commitment to learn and implement healthy changes which will improve your health and well-being? Rate from 1-10. (10 being the most commitment)

a) If below 8 what will it take to increase your level of commitment?

8. What do you believe your present lifestyle and state of health is costing you in future health, longevity, % energy of each day, quality of life and/or relationships, peace of mind and happiness?

9. What are your top three priorities or values in your life presently?

10. What resources do you currently allocate to your health and well being? i.e. how much time, money and energy do you invest in your health right now?

11. How much time, money and energy are you willing to invest in your health?

12. What obstacles do you feel exist in your life that can prevent you from achieving your goals for your health, peace of mind and happiness?

Please note **if you want** or **object to** any of these services, or have **questions** about:

Homeopathy Herbal Remedies Acupuncture

Cranio- Sacral Massage Counseling Hydrotherapy

Nutritional Education Vitamin Supplements Thai Massage

Meditation Education Qi Gong Education