Snohomish Naturopathic Clinic
1101 Avenue D, Suite D103, Snohomish, WA 98290
Phone: 360.568.2686 Fax: 360.862.8016
www.SnohomishNaturopathic.com

Achieve Optimal Health

Health History

Date _____ Name _____ Age _____ Date of Birth _____

Occupation: _____ Retired Disability Unemployed

REASON FOR VISIT TODAY _____

History of Present Illness *(Please answer the following questions-NA if not applicable)*

Location of Problem_____
When did you first notice problem? _____
How long does problem last? _____
Is the problem constant or variable? _____ If variable, when/where does it happen? _____
What does it feel like (dull, sharp, burning, ache, throbbing, numbness, etc.)? _____
Does anything help or make problem better or worse (lying on side, standing, moving, etc.)? _____
Is anything occurring at the same time (rash, headache, nausea, etc.)? _____
How does problem rate? 1 2 3 4 5 6 7 8 9 10 (worst)
Does problem interfere with your normal function? _____
If yes, please explain_____

PLEASE LIST ANY **ALLERGIES** TO **MEDICINES** OR **FOODS**:

Please list all **MEDICATIONS** *(include over the counter medications)*

Medication	Dosage (mg, mcg, etc.)	Medication	Dosage (mg, mcg, etc.)

Please list all **SUPPLEMENTS** *(vitamins, minerals, herbal preparations etc.)*

Supplement (type & brand	Dosage (mg, mcg, etc.)	Supplement (type & brand	Dosage (mg, mcg, etc.)

Please list any **SURGERIES** or **HOSPITALIZATIONS** and dates

Type of Surgery or reason for hospitalization	Date(s)	Type of Surgery or reason for hospitalization	Date(s)

Past Medical & Family Medical History [***NOTE:*** *family is your mother, father, brother(s), or sister(s)]*

	Self	Family		Self	Family		Self	Family
Alcoholism			Diabetes			High Blood Pressure		
Arthritis			Depression			Kidney Disease		
Asthma			Emphysema			Tuberculosis		
Blood Disorder			Glaucoma			Thyroid Disease		
Cancer – Type?			Heart Disease			OTHER		

Birth Mother	(please circle)	Living / Deceased / Unknown	Age _____	Cause of death if deceased _____
Birth Father	(please circle)	Living / Deceased / Unknown	Age _____	Cause of death if deceased _____
Sis / Bro	(please circle)	Living / Deceased / Unknown	Age _____	Cause of death if deceased _____
Sis / Bro	(please circle)	Living / Deceased / Unknown	Age _____	Cause of death if deceased _____
Sis / Bro	(please circle)	Living / Deceased / Unknown	Age _____	Cause of death if deceased _____
Sis / Bro	(please circle)	Living / Deceased / Unknown	Age _____	Cause of death if deceased _____
Sis / Bro	(please circle)	Living / Deceased / Unknown	Age _____	Cause of death if deceased _____

PLEASE TURN OVER & FILL OUT THE BACK SIDE OF THIS FORM. Thank you!

Are you currently: single / married / divorced / widower? How long? _____
Have you been married more than once? Yes / No If yes, how many times? _____
If you have Children: How Many? _____ What is/are their gender(s) and age(s)? _____
_____
Are you currently sexually active? Yes / No Are you sexually active with (please circle) Men / Women / Both
Do you currently have more than one sex partner? Yes / No Current form of birth control _____
Do you use condoms or other barrier method? Yes / No Any history of a sexually transmitted disease? Yes / No

Do you smoke cigarettes? Yes / No If yes, how many pack(s) per day? _____ Quit? Yes / No When? _____
Do you use any other tobacco products (cigars, chewing tobacco, snuff, etc.)? Type _____ Amount _____
Do you drink alcohol? Never Occasional Moderate Heavy Quit when? _____
Do you use recreational drugs? Yes / No Type _____ Frequency _____
Do you drink coffee? Yes / No Cups per day: _____ Sodas? Yes / No Type _____ Cans per day_____

Do you exercise regularly? Yes / No Describe_____
Has a doctor ever told you that you have a bone or joint problem that may be aggravated by exercise? Yes / No
Is your sleep restful? Yes / No Hours per night_____ Do you wake feeling refreshed in the morning? Yes / No

Date of your last menstrual period (or menopause)_____ Are your periods regular? Yes / No
#Pregnancies _____ #Births _____ #Miscarriage(s)_____ #Abortions _____ #Living Children _____
Date of last PAP _____ Any history of an abnormal PAP? Yes / No When? _____
Date of last Mammogram? _____ Any history of an abnormal mammogram? Yes / No When? _____

REVIEW OF SYSTEMS *(please circle 'Y'-yes or 'N'-no)*

Constitutional Symptoms			**Gastrointestinal**			**Genitourinary**		
Fatigue	Y	N	Abdominal Pain	Y	N	Urine Retention	Y	N
Chills	Y	N	Nausea/Vomiting	Y	N	Painful Urination	Y	N
Headache	Y	N	Indigestion/Heartburn	Y	N	Urinary Frequency	Y	N
Fever	Y	N	Diarrhea	Y	N	Nighttime Urination	Y	N
Other	Y	N	Constipation	Y	N	Other	Y	N
Eyes			Other	Y	N	**Respiratory**		
Blurred Vision	Y	N	**Cardiovascular**			Wheezing	Y	N
Double Vision	Y	N	Chest Pain	Y	N	Frequent Cough	Y	N
Pain	Y	N	Varicose Veins	Y	N	Shortness of Breath	Y	N
Other	Y	N	High Blood Pressure	Y	N	Other	Y	N
Allergic/Immunologic			Other	Y	N	**Hematologic/Lymphatic**		
Hay Fever	Y	N	**Integumentary**			Swollen Glands	Y	N
Drug Allergies	Y	N	Skin Rash	Y	N	Blood Clotting Disorder	Y	N
Other	Y	N	Boils	Y	N	Other	Y	N
Neurological			Persistent Itch	Y	N	**Psychologic**		
Tremors	Y	N	Other	Y	N	Are you Generally satisfied with your life?	Y	N
Dizzy Spells	Y	N	**Musculoskeletal**					
Numbness/Tingling	Y	N	Joint Pain	Y	N	Do you feel severely depressed?	Y	N
Other	Y	N	Neck Pain	Y	N			
Endocrine			Back Pain	Y	N	Have you ever considered suicide?	Y	N
Excessive Thirst	Y	N	Other	Y	N			
Too Hot	Y	N	**Ear/Nose/Throat/Mouth**					
Too Cold	Y	N	Ear Infection	Y	N	**# of Answers**	**Level of Service**	
Tired or Sluggish	Y	N	Sore Throat	Y	N	**0-1**	**1or 2**	
Other	Y	N	Sinus Congestion	Y	N	**2-9**	**3**	
			Other	Y	N	**10+**	**4 or 5**	

Are you currently seeing any health care professionals (Naturopath, Medical Doctor, Chiropractor, etc.)? Yes / No
What are their names and where are they located?

Are there ANY other issues that you would like to mention or discuss?