

# *Naturopathy Lifestyles*



Promoting  
Healthy  
Living

## Health Assessment

Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Telephone Number(s): Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Relationships: Married  Partnership  Single  Widowed  Divorced

Occupation: \_\_\_\_\_ Hours per week \_\_\_\_\_

Height: \_\_\_ft \_\_\_in Weight: \_\_\_\_\_ pounds Recent Weight Gain/Loss: \_\_\_\_\_

### Allergies

Drugs	Foods	Environmental	Chemicals

### Medications

Medication	Dose	Frequency	Reason

### Supplements

Supplement	Dose	Frequency	Reason

### Previous Hospitalizations

Date	Reason	Surgery	Outcome

### Current Therapies

Date	Therapy	Reason	Outcome

### Immunizations

	Yes	No		Yes	No
Polio	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input type="checkbox"/>	<input type="checkbox"/>	Other	_____	

### Health History

**Current Health Issue(s):**

Include: date problem began, signs and symptoms, current treatments/medications

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Physical Stressors:**

**Emotional Stressors:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Health Consultant/Practitioner(s):**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

### Family History

Number of Children \_\_\_\_\_

Immediate Family Support \_\_\_\_\_

Indicate if you or an immediate family member has a history of any of the following:

	Self	Family		Self	Family
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>

Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Prostrate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Rashes/Itching	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Urinary/Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Hyper/Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>			

### Typical Daily Diet

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Drinks: \_\_\_\_\_

### Diet Habits

	Yes	No
Do you eat three meals a day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat out often?	<input type="checkbox"/>	<input type="checkbox"/>

Do you drink coffee/tea/sodas?

Do you drink alcohol?

Do you eat refined sugar?

**Elimination**

**Yes No**

Problems Urinating

Bowel Movements Daily

Explain Elimination Problems: \_\_\_\_\_

**Sleep Habits**

**Yes No**

Average 6-8 hours of sleep per night

Awake Refreshed

**Exercise**

Daily Exercise/activities: \_\_\_\_\_

**Systems Review**

SYSTEM	SIGNS & SYMPTOMS (please circle & check yes or no to s/s that apply)	YES	NO
<b>HEAD</b>			
	Headaches, Migraines		
	Head Injury		
	Jaw Problems		
<b>EYES</b>			
	Spots, Blurring, Pain, Tearing/Dryness, Double Vision		
	Glasses/contact lenses		

	Color Blindness		
	Cataracts		
	Glaucoma		
<b>EARS</b>			
	Earaches		
	Ringing		
	Dizziness		
<b>NOSE/SINUSES</b>			
	Congestion, Loss of Smell, Nose Bleeds		
	Frequent Colds		
	Hay Fever		
<b>MOUTH &amp; THROAT</b>			
	Sore tongue/lips		
	Jaw Clicks		
	Copious saliva		
	Frequent sore throat/hoarseness		
	Dental cavities/gum problems		
<b>NECK</b>			
	Swollen Glands		
	Pain/stiffness		
<b>RESPIRATORY</b>			
	Cough – productive/non-productive		
	Shortness of Breath, sitting/lying down		
	Pain		
	Wheezing		
<b>CARDIOVASCULAR</b>			
	High/low Blood Pressure		
	Heart Palpations/fluttering		
	Chest Pain, Pain in Arms		
	Swelling to lower extremities		
	Easy bruising/bleeding		
	Leg Pain		
	Cold hands and feet		
<b>GASTROINTESTINAL</b>			
	Problems swallowing		
	Change in appetite		
	Change in Thirst		
	Nausea/vomiting		
	Belching or passing gas		
	Bowel Movements daily		
	Constipation/diarrhea		
	Black Stools		
	Hemorrhoids		
<b>URINARY</b>			
	Pain on Urination		
	Hesitancy		

	Frequency		
	Incontinence		
<b>MUSCULOSLELETAL</b>			
	Joint pain/stiffness		
	Muscle spasms/cramps		
	Weakness		
<b>SKIN</b>			
	Acne, boils, rashes, hives		
	Itching		
	Moles/changes		
	Hair loss		

### Informed Consent for Naturopathic Services

Naturopathic care is concerned with the use of natural means, and remedies to further health and wellness. Naturopathic care includes: assessment, education, nutritional counseling, herbal, and homeopathic remedies, lifestyle modifications, and other natural interventions.

I, \_\_\_\_\_, do hereby give my informed and voluntary consent for Naturopathic care by **Ann Marie Malden** RN, BSN, MBA/HCM, ND

I certify that I understand the nature of this health care method, including the risks of possible adverse reactions. I have been adequately informed, and questions I have asked have been satisfactorily answered.

I authorize release of my personal medical records from my primary physician to Naturopathy Lifestyles, and other health care providers, and insurance companies/payers as necessary to complete my care. All information is treated in the strictest confidentiality as per the HIPPA guidelines.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**