

Naturopathic Adult Health Assessment

Name: _____ Age: _____ Sex: M F Date: _____

Address: _____ Blood Type: A B AB O (+) (-) Unsure?

City, State, ZIP: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Email: _____ Fax: _____

Date of Birth: _____ SS#: _____ Ht: _____ Wt: _____ Wt at 20 yr: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Known Allergies: _____

Referral Source _____

PRIMARY HEALTH CONCERNS:

In your opinion, what are your most important health concerns?

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Others: _____

What are your current health goals? _____

Please check any medical treatments you have used:

Acupuncture Chiropractic Herbal Medicine Energy Work Physical Therapy

Biofeedback Counseling Homeopathy Naturopathy Therapeutic Massage

Other treatments you have received: _____

Is there any condition, trauma, or incident after which you have never been totally well again? _____

On a scale of 1 – 10, how would you rate your current overall state of health? _____

Over the past year has your state of health: Improved Worsened Stayed the Same;

Over the past year have you gained weight: Yes (amount): _____ No

CURRENT MEDICATIONS & SUPPLEMENTS:

Current Medications	Dose	Date Started	Prescribed by

Have you ever been prescribed the following?

- Anti-Inflammatories (e.g., Motrin) Muscle Relaxants Pain Pills
 Steroids Antidepressants Contraceptives (specify type): _____

Vitamins, herbal preparations and supplements	Dose	Date Started	Prescribed by

Allergies and reactions to medications: _____

Allergies and reactions to natural supplements: _____

Other allergies: _____

HEALTH HISTORY – ADULTHOOD:

Please indicate whether you or an immediate relative has ever had the following diseases or conditions:

Disease	Self	Age at onset	Which Relative? (indicate if deceased-D)
Angina/MI/Heart Attack			
High Blood Pressure			
Stroke			
Blood Clot			
High Cholesterol			
Obesity			
Thyroid Disorder			
Diabetes			
Ulcer, GI Bleeding			
Irritable Bowel Syndrome			
Inflammatory Bowel Disease			
Celiac Disease			
Heartburn/Reflux			
Asthma			
Hay Fever/Allergies			
Tuberculosis			
Emphysema			
Pneumonia			
Eczema			
Psoriasis			
Liver Disease/Hepatitis			
Substance Addiction			
Other			

Disease	Self	Age at onset	Which Relative? (indicate if deceased-D)
Epilepsy/Seizures			
Alzheimer’s Disease			
Parkinson’s			
Back problems/sciatica			
Headache			
Anemia			
Mononucleosis			
Depression			
Chronic Fatigue			
Fibromyalgia			
Nervous Exhaustion			
Glaucoma			
Macular Degeneration			
Night Blindness			
Arthritis/Rheumatism			
Cancer Specify: _____			
Kidney, Bladder			
Osteoporosis			
Gout			
Injury (serious)			
Venereal Disease (STDs) Specify _____			
AIDS			

Please list all past hospitalizations, operations, serious illnesses, traumas:

Month/Year:

HEALTH MAINTENANCE: Please list any significant findings and the date of your last visit for the following exams:

Exam Type	Significant Findings	Date of Last Visit
Routine Exam	_____	_____
Pap/Pelvic	_____	_____
Breast/Mammogram	_____	_____
Prostate Exam	_____	_____
Hemocult	_____	_____
Flexible Sigmoidoscopy	_____	_____
Retinal Eye Exam	_____	_____
Dental Exam	_____	_____
Describe any dental work done:	_____	
Describe oral Hygiene practice:	_____	

HEALTH HISTORY – CHILDHOOD (check all that apply):

- Measles Whooping Cough Diabetes Mumps Strep/Tonsillitis
- Chicken Pox Polio Appendicitis Rubella Diphtheria
- Sinus Infections Ear Infections Pneumonia Eczema Asthma
- Other: _____

At the time of your birth, did you experience any unusual birth trauma: Yes No

If yes, please explain: _____

PSYCHOLOGICAL:

How would you rate your overall level of stress (with 1 being No Stress, and 10 being Unbearable Stress)?

- 1 2 3 4 5 6 7 8 9 10

What types of things cause you stress? _____

What symptoms of stress have you experienced? _____

Please list any significant stressors you have experienced (e.g., accidents, divorce, death, change or loss of job, ending of relationship, etc):

Type of stressor:

Month/Year:

How do you characterize your relationships (spouses/partners, family, friends, co-workers, etc)? _____

Have you ever been diagnosed with a psychiatric condition? Yes No If Yes, when and how were you treated?

LIFESTYLE HABITS:

How frequently do you exercise?

- Daily or almost daily 3-5 times a week 1-2 times a week 2-4 times a month Almost never

What types of exercise do you do? _____

Do you practice any form of meditation or relaxation techniques? Yes No If Yes, what types and how often? _____

How would you describe your sleep patterns? _____

Time you go to bed: _____ pm/am Time you wake up: _____ am/pm

If you have difficulties falling asleep, how long does it take you to and what keeps you up? _____

Do you wake during the night, and if so what wakes you? _____

If you wake during the night, do you fall back to sleep easily? _____

Any other concerns with sleep that you would like addressed? _____

Do you follow any spiritual practices? Yes No If yes, what are they? _____

Occupation: _____ Employer: _____

Living Situation: Married Single Divorced Widowed Children (number): _____ Children's Ages: _____

Prefer intimate relations with: Male Female Male and female

EXPOSURES:

Please record your exposure to the following:

Tobacco/Recreational Drugs	Age started	Duration in years	Average amount/day	Current Use	
				Yes	No
Smoking/Chewing tobacco					
Second hand smoke					
Recreational drugs					

Please record your consumption of the following:

Beverages	Yes	No	# of cups/cans/glasses per day
Coffee			
Soda/Diet Soda			
Caffeinated Beverages			
Tea			
Beer			
Wine			
Mixed Drinks			

Have you ever been exposed to toxic chemicals, solvents or other possible toxins? Yes No

If yes, please explain: _____

Food Plan Instructions:

Name: _____ **Date:** _____

- Please record, in honesty, what you eat for a few days. It will benefit you more to be real and not ideal!
- Include condiments, drinks, snacks, supplements (vitamins/minerals/herbs/homeopathic remedies).
- Include any comments, symptoms (emotional/mental/physical), energy levels, etc at the end of each column for each day.
- Be specific in your recordings by including what type of food is eaten (“white bread” or “whole wheat bread”), the quantity (cups, tsp, oz, etc), how it was prepared (baked, boiled, deep fried, etc) and the time of day it was eaten.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

How many meals do you generally eat each day? One Two Three More than three

How often do you skip meals? Never Once or twice a month Once a week More than once a week

Where do you usually buy your food? _____

Who cooks the food you eat? _____

List the foods you exclude from your diet and why: _____

List any foods you crave, regardless of their nutritional value: _____

List any foods to which you have a bad reaction and how you react: _____

Are you thirsty? No Yes Amount of plain water you drink each day _____

What type of water do you drink? Distilled water Filtered Spring Well Deionized Tap

At what temperature do you prefer to drink liquids? Hot Cold Room temp

Health Appraisal Questionnaire

Instructions: Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.

0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe

PART 1			
SECTION A:		SECTION C:	
1. Burping.....	0 1 2 3	1. Stomach pains.....	0 1 2 3
2. Fullness for extended time after meals	0 1 2 3	2. Stomach pains just after meals.....	0 1 2 3
3. Bloating.....	0 1 2 3	3. Dependency on antacids	0 1 2 3
4. Poor appetite.....	0 1 2 3	4. Chronic abdominal pain.....	0 1 2 3
6. History of constipation	0 1 2 3	5. Butterfly sensations in stomach	0 1 2 3
7. Known food allergies	0 1 2 3	6. Difficulty belching.....	0 1 2 3
SECTION B:		7. Stomach pain when emotionally upset.....	0 1 2 3
1. Abdominal cramps	0 1 2 3	8. Sudden, acute indigestion	NO YES
2. Indigestion 1-3 hours after eating	0 1 2 3	9. Relief of symptoms by carbonated beverages	NO YES
3. Fatigue after eating.....	0 1 2 3	10. Relief of stomach pain by eating or with dairy	NO YES
4. Lower bowel gas	0 1 2 3	11. History of ulcer or gastritis	NO YES
5. Alternating constipation and diarrhea.....	0 1 2 3	12. Current ulcer.....	NO YES
6. Diarrhea.....	0 1 2 3	13. Black stool when not taking iron supplements.....	NO YES
7. Roughage and fiber causes constipation	0 1 2 3	SECTION D:	
8. Mucous in stools.....	0 1 2 3	1. Frequent and recurrent infections (colds).....	0 1 2 3
9. Stool poorly formed.....	0 1 2 3	2. Bladder and kidney infections	0 1 2 3
10. Shiny stool.....	0 1 2 3	3. Vaginal yeast infection	0 1 2 3
11. Three or more large bowel movements daily.....	0 1 2 3	4. Toe and fingernail fungus.....	0 1 2 3
12. Foul smelling stool	0 1 2 3	5. Alternating diarrhea/constipation.....	0 1 2 3
13. Dry, flaky skin and/or brittle hair	0 1 2 3	6. Constipation.....	0 1 2 3
14. Pain in left side under rib cage	0 1 2 3	7. History of antibiotic exposure.....	NO YES
15. Acne	0 1 2 3	8. Meat eater	NO YES
16. Food allergies	0 1 2 3	9. Vegetarian	NO YES
17. Difficulty gaining weight.....	0 1 2 3	10. Rapidly failing vision	NO YES

PART 2			
SECTION A:		SECTION B:	
1. Difficulty breathing at night	0 1 2 3	1. Cold hands and feet.....	0 1 2 3
2. Chest pain while walking	0 1 2 3	2. Slurred speech.....	0 1 2 3
3. Heaviness in legs	0 1 2 3	3. Calf muscles cramp while walking	0 1 2 3
4. Calf muscles cramp while walking	0 1 2 3	4. Headaches.....	0 1 2 3
5. Heart pounds easily	0 1 2 3	5. Numbness in extremities.....	0 1 2 3
6. Feel jittery	0 1 2 3	6. Poor concentration	0 1 2 3
7. Heart misses beats or as extra beats	0 1 2 3	7. Ringing in ears.....	0 1 2 3
8. Swelling of feet and ankles.....	0 1 2 3	8. Ear canal hair.....	0 1 2 3
9. Rapid beating heart.....	0 1 2 3	9. Tingling and/or burning in hands or feet.....	0 1 2 3
10. Heartburn after eating.....	0 1 2 3	10. Spider veins on nose and/or face.....	0 1 2 3
11. Pain in left arm.....	0 1 2 3	SECTION C:	
12. Exhaustion with minor exertion.....	0 1 2 3	1. Pain when getting up in morning in back	
13. Do you do aerobic exercise.....	YES NO	of head and neck	0 1 2 3
14. Have you ever exercised regularly.....	YES NO	2. Dizziness.....	0 1 2 3
15. Drink 5 or more cups of coffee daily	NO YES	3. Vertigo.....	0 1 2 3
16. Severe cough	NO YES	4. Blushing with no apparent cause.....	0 1 2 3
17. Has a doctor ever told you that you have		5. Is your blood pressure high?	NO YES
heart trouble	NO YES		

PART 3			
SECTION A:		SECTION B:	
1. Dizziness when standing suddenly	0 1 2 3	1. Night sweats	0 1 2 3
2. Loss of vision when standing suddenly	0 1 2 3	2. Increased thirst.....	0 1 2 3
3. Crave sweets.....	0 1 2 3	3. Lowered resistance to infection	0 1 2 3
4. Headaches relieved by eating sweets or alcohol.....	0 1 2 3	4. Fatigue	0 1 2 3
5. Feel shaky or jittery	0 1 2 3	5. Boils and leg sores	0 1 2 3
6. Irritable if a meal is missed.....	0 1 2 3	6. Lesions, cuts take a long time to heal.....	0 1 2 3
7. Wake up in middle of night craving sweets	0 1 2 3	7. Overweight	0 1 2 3
8. Feel tired or weak if a meal is missed.....	0 1 2 3	8. Feel pick up from exercise	0 1 2 3
9. Hear palpitations after eating sweets	0 1 2 3	9. Failing eyesight.....	0 1 2 3
10. Need to drink coffee to get started	0 1 2 3	10. Crave sweets, but eating sweets does	
11. Impatient, moody, nervous	0 1 2 3	not relieve symptoms	0 1 2 3
12. Feel tired 1 to 3 hours after eating	0 1 2 3	11. Family history of diabetes.....	0 1 2 3
13. Poor memory.....	0 1 2 3	12. Sugar in urine.....	0 1 2 3
14. Feel faint	0 1 2 3		
15. Poor concentration.....	0 1 2 3		
16. Forgetful	0 1 2 3		
		17. Calmer after eating	0 1 2 3

PART 4**SECTION A:**

1. Intolerance to greasy foods.....	0	1	2	3
2. Headaches after eating.....	0	1	2	3
3. Light colored stool.....	0	1	2	3
4. Foul smelling stool.....	0	1	2	3
5. Less than one bowel movement daily.....	0	1	2	3
6. Constipation.....	0	1	2	3
7. Hard stool.....	0	1	2	3
8. Sour taste in mouth.....	0	1	2	3
9. Grey colored skin.....	0	1	2	3
10. Yellow in whites of eyes.....	0	1	2	3
11. Bad breath.....	0	1	2	3
12. Body odor.....	0	1	2	3
13. Fatigue and sleepiness after eating.....	0	1	2	3
14. Pain in right side under rib cage.....	0	1	2	3
15. Painful to pass stool.....	0	1	2	3
16. Retain water.....	0	1	2	3
17. Big toe painful.....	0	1	2	3
18. Pain radiates along outside of leg.....	0	1	2	3
19. Dry skin/hair.....	0	1	2	3
20. Red blood in stool.....	NO			YES
21. Have had jaundice or hepatitis.....	0	1	2	3
22. High blood cholesterol level and low HDL cholesterol.....	0	1	2	3
23. Is your cholesterol level above 200.....	NO	UNKNOWN		YES
24. Is your triglyceride level above 115.....	NO	UNKNOWN		YES

SECTION B:

1. Swollen eyes (bulging).....	0	1	2	3
2. Strong smelling urine.....	0	1	2	3
3. Thick skin and finger nails.....	0	1	2	3
4. Dry skin.....	0	1	2	3
5. Sensitive to the cold.....	0	1	2	3
6. Cold hands and feet.....	0	1	2	3
7. Excessive menstrual bleeding.....	0	1	2	3
8. Chronic fatigue.....	0	1	2	3
9. Trouble waking up in the morning.....	0	1	2	3
10. Depressed, apathetic.....	0	1	2	3
11. Low sex drive.....	0	1	2	3
12. Puffy, wrinkly skin.....	0	1	2	3
13. Sugar causes irritability and mood swings.....	0	1	2	3
14. Premenstrual tension.....	0	1	2	3
15. Constipation.....	0	1	2	3
16. Thinning or loss of outside portion of eyebrow.....	0	1	2	3
17. Gain weight easily.....	0	1	2	3
18. Anemia unaffected by iron.....	0	1	2	3
19. Axillary (armpit) temperature below 97.6°F.....	0	1	2	3
20. Slow reflexes.....	0	1	2	3
21. Infertility.....	0	1	2	3

PART 5**SECTION A:**

1. Sensitive to exhaust fumes, smoke, smog, petrochemicals.....	0	1	2	3
2. Periodic constipation.....	0	1	2	3
3. Cannot tolerate exercise.....	0	1	2	3
4. Depression or rapid mood swings.....	0	1	2	3
5. Dark circles under the eyes.....	0	1	2	3
6. Dizziness upon standing.....	0	1	2	3
7. Lack of mental alertness.....	0	1	2	3
8. Catch colds easily when weather changes.....	0	1	2	3
9. Headaches.....	0	1	2	3
10. Difficulty breathing.....	0	1	2	3
11. Water retention.....	0	1	2	3
12. Eyes sensitive to bright light.....	0	1	2	3
13. Feel weak and shaky.....	0	1	2	3

SECTION B:

1. Inflamed and bleeding gums.....	0	1	2	3
2. Running nose.....	0	1	2	3
3. Get boils or styes.....	0	1	2	3
4. Nose bleeds.....	0	1	2	3
5. Loss of smell.....	0	1	2	3
6. Throat infections.....	0	1	2	3
7. Cold sores, fever blisters.....	0	1	2	3
8. Loss of taste.....	0	1	2	3
9. Poor wound healing.....	0	1	2	3
10. Hair falls out.....	0	1	2	3
11. Swollen lymph glands.....	0	1	2	3
12. Ear infection.....	0	1	2	3
13. Hair grows slowly.....	0	1	2	3

14. Slow to recover from cold or flu.....	0	1	2	3
15. Catch colds or flu easily.....	0	1	2	3
16. Bumpy skin on back of arms.....	0	1	2	3

SECTION C:

1. Itching of nose or eyes.....	0	1	2	3
2. Itching of roof of mouth or throat.....	0	1	2	3
3. Migraine headaches.....	NO			YES
4. Entire body aches, painful to touch.....	0	1	2	3
5. Swollen joints.....	0	1	2	3
6. Food sensitivity or allergy.....	0	1	2	3
7. Certain foods make you sick, depressed, jittery.....	0	1	2	3
8. Chronic pain.....	0	1	2	3
9. Painful stomach and/or intestine.....	0	1	2	3
10. Alternating constipation and diarrhea.....	0	1	2	3
11. Mucous in throat.....	0	1	2	3
12. Post nasal drip.....	0	1	2	3
13. Discharge from eyes.....	0	1	2	3
14. Watery eyes.....	0	1	2	3
15. Puffiness or dark circles under eyes.....	0	1	2	3
16. Ear discharge or ears stuffed up.....	0	1	2	3
17. Nasal congestion.....	0	1	2	3
18. Running nose.....	0	1	2	3
19. Breathe through mouth.....	0	1	2	3
20. Swollen tongue.....	0	1	2	3
21. Difficulty swallowing.....	0	1	2	3
22. Bedwetting.....	NO			YES
23. Hyperactivity.....	0	1	2	3
24. Chronic lung congestion.....	0	1	2	3
25. Use of aspirin, tylenol regularly.....	NO			YES
26. Wheezing.....	0	1	2	3
27. Skin rashes.....	0	1	2	3
28. Sneezing.....	0	1	2	3

PART 6

1. Chest pain.....	0	1	2	3
2. Chronic cough.....	0	1	2	3
3. Difficulty breathing.....	0	1	2	3
4. Coughing up blood.....	0	1	2	3
5. Coughing up phlegm.....	0	1	2	3
6. Pain around ribs.....	0	1	2	3
7. Shortness of breath.....	0	1	2	3
8. Rattling mucous when you breathe.....	0	1	2	3
9. Sensitive to smog.....	0	1	2	3
10. Infections settle in lungs.....	0	1	2	3
11. Live or work around people who smoke.....	0	1	2	3
12. Bronchitis.....	0	1	2	3
13. Exposed to chemicals and radiation.....	0	1	2	3
14. Smoker.....	0	1	2	3

PART 7

- | | | | | | | | | | |
|---|---|---|---|---|---|----|---|---|-------|
| 1. Frequent urination | 0 | 1 | 2 | 3 | 11. Strong smelling urine | 0 | 1 | 2 | 3 |
| 2. Frequent bladder infections | 0 | 1 | 2 | 3 | 12. Back or leg pains associated with | | | | |
| 3. Rarely need to urinate | 0 | 1 | 2 | 3 | dripping after urination | 0 | 1 | 2 | 3 |
| 4. Urination when you cough or sneeze | 0 | 1 | 2 | 3 | 13. History of kidney or bladder infections | 0 | 1 | 2 | 3 |
| 5. Painful/burning when passing urine | 0 | 1 | 2 | 3 | 14. Have used antibiotics to control | | | | |
| 6. Difficulty passing urine | 0 | 1 | 2 | 3 | urinary tract infections | NO | | | YES |
| 7. Dripping after urination | 0 | 1 | 2 | 3 | IF YES, WHEN DID YOU LAST USE THEM? | | | | _____ |
| 8. Can't hold urine | 0 | 1 | 2 | 3 | TREATMENT DURATION | | | | _____ |
| 9. Rose colored (bloody urine) | 0 | 1 | 2 | 3 | 15. Back pain in the kidney area | 0 | 1 | 2 | 3 |
| 10. Cloudy urine | 0 | 1 | 2 | 3 | 16. General water retention | 0 | 1 | 2 | 3 |

PART 8 (Males Only)

SECTION A:

- | | | | | |
|---|---|---|---|---|
| 1. Difficulty urinating | 0 | 1 | 2 | 3 |
| 2. A sense of bladder fullness | 0 | 1 | 2 | 3 |
| 3. Increased straining with smaller and smaller | | | | |
| amounts of urine passed | 0 | 1 | 2 | 3 |
| 4. Rose colored (bloody) urine | 0 | 1 | 2 | 3 |
| 5. Pain or burning while urinating | 0 | 1 | 2 | 3 |
| 6. Wake up to urinate at night | 0 | 1 | 2 | 3 |
| 7. Dripping after urination | 0 | 1 | 2 | 3 |
| 8. Pain or fatigue in the legs or back | 0 | 1 | 2 | 3 |
| 9. Lack of sex drive | 0 | 1 | 2 | 3 |
| 10. Ejaculation causes pain | 0 | 1 | 2 | 3 |

SECTION B:

- | | | | | |
|--|---|---|---|---|
| 1. Difficulty attaining and/or maintaining an erection | 0 | 1 | 2 | 3 |
| 2. Low sexual drive | 0 | 1 | 2 | 3 |
| 3. Premature ejaculation | 0 | 1 | 2 | 3 |
| 4. Pain/coldness in genital area | 0 | 1 | 2 | 3 |
| 5. Infertile | 0 | 1 | 2 | 3 |
| 6. Varicose veins on scrotum | 0 | 1 | 2 | 3 |
| 7. Low sperm count | 0 | 1 | 2 | 3 |

SECTION C:

- | | | | | |
|--|-------|---|---|--------------------|
| 1. Discharge from penis | 0 | 1 | 2 | 3 |
| 2. Past or present rash on penis | 0 | 1 | 2 | 3 |
| 3. Swollen genitals | 0 | 1 | 2 | 3 |
| 4. Swelling in groin | 0 | 1 | 2 | 3 |
| 5. Venereal disease (gonorrhea, syphilis | | | | |
| Herpes or other) | NO | | | YES |
| Have V.D. now? | _____ | | | Had in past? |
| | | | | _____ |

PART 9 (Females Only)

SECTION A: Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation. (Section A only)

- | | | | | |
|------------------------------------|-------|---|---|---|
| 1. Monthly weight gain | 0 | 1 | 2 | 3 |
| 2. Depression | 0 | 1 | 2 | 3 |
| 3. Moodiness/irritability | 0 | 1 | 2 | 3 |
| 4. Bloating and swelling | 0 | 1 | 2 | 3 |
| 5. Nausea and/or vomiting | 0 | 1 | 2 | 3 |
| 6. Suicidal feeling | 0 | 1 | 2 | 3 |
| 7. Anxiety | 0 | 1 | 2 | 3 |
| 8. Leg cramps and tenderness | 0 | 1 | 2 | 3 |
| 9. Asthma attacks | 0 | 1 | 2 | 3 |
| 10. Headaches | 0 | 1 | 2 | 3 |
| 11. Easily distracted | 0 | 1 | 2 | 3 |
| 12. Anger | 0 | 1 | 2 | 3 |
| 13. Tender breast | 0 | 1 | 2 | 3 |
| 14. Low backache | 0 | 1 | 2 | 3 |
| 15. Other | 0 | 1 | 2 | 3 |
| 16. Age of onset of menses | _____ | | | |
| 17. Date of last menses | _____ | | | |

SECTION B:

- | | | | | |
|--|----|---|---------------|-------|
| 1. Vaginal itching | 0 | 1 | 2 | 3 |
| 2. Vaginal discharge | 0 | 1 | 2 | 3 |
| 3. Low or no desire for sex | 0 | 1 | 2 | 3 |
| 4. Dislike for intercourse | 0 | 1 | 2 | 3 |
| 5. Missed periods | NO | | | YES |
| 6. Over 15 years old and have not begun menstruation | NO | | | YES |
| 7. Unable to get pregnant | NO | | | YES |
| 8. Miscarriages | NO | | YES HOW MANY? | _____ |
| 9. Abortion | NO | | YES HOW MANY? | _____ |

SECTION C: Check if you experience during menstruation (Section C only)

- | | | | | |
|--|---|---|---|---|
| 1. Low abdominal pain | 0 | 1 | 2 | 3 |
| 2. Dull ache radiating to low back or legs | 0 | 1 | 2 | 3 |
| 3. Increased urinary frequency | 0 | 1 | 2 | 3 |
| 4. Pelvic soreness | 0 | 1 | 2 | 3 |
| 5. Diarrhea | 0 | 1 | 2 | 3 |
| 6. Headaches | 0 | 1 | 2 | 3 |
| 7. Abdominal bloating | 0 | 1 | 2 | 3 |
| 8. Menstrual pain | 0 | 1 | 2 | 3 |

- | | | | | |
|---|---|---|---|---|
| 9. Nausea and/or vomiting | 0 | 1 | 2 | 3 |
| 10. Have to lie down on first 1 or 2 days of period | 0 | 1 | 2 | 3 |
| 11. Craving for sweets | 0 | 1 | 2 | 3 |
| 12. Insomnia | 0 | 1 | 2 | 3 |
| 13. Light scanty blood flow | 0 | 1 | 2 | 3 |
| 14. Pain and cramps without blood flow | 0 | 1 | 2 | 3 |
| 15. Heavy menstrual bleeding | 0 | 1 | 2 | 3 |
| 16. Anxiety about menstrual cycle | 0 | 1 | 2 | 3 |
| 17. Pain during period is progressively getting | | | | |
| worse with time | 0 | 1 | 2 | 3 |

SECTION D:

- | | | | | |
|---|----|---|---|-------|
| 1. Vaginal bumps and sores | 0 | 1 | 2 | 3 |
| 2. Pubic area sore | 0 | 1 | 2 | 3 |
| 3. Ovarian cysts or painful ovaries | NO | | | YES |
| 4. Uterine cysts | NO | | | YES |
| 5. Breast lumps | NO | | | YES |
| 6. Breasts sore to touch | 0 | 1 | 2 | 3 |
| 7. Breasts painful | 0 | 1 | 2 | 3 |
| 8. Water retention | 0 | 1 | 2 | 3 |
| 9. Swollen feeling | 0 | 1 | 2 | 3 |
| 10. Premenstrual breast pain or discomfort | 0 | 1 | 2 | 3 |
| 11. Mother used D.E.S. (hormones) while pregnant | NO | | | YES |
| 12. Recent pap smear positive | NO | | | YES |
| 13. Family history of breast cancer | NO | | | YES |
| 14. Form of birth control: ___None ___Pill ___IUD ___Sponge | | | | |
| ___Diaphragm ___Foam Other | | | | _____ |

SECTION E:

- | | | | | |
|--|---|---|---|---|
| 1. Hot flashes | 0 | 1 | 2 | 3 |
| 2. Night sweats | 0 | 1 | 2 | 3 |
| 3. Hysterectomy | 0 | 1 | 2 | 3 |
| 4. Depression/mood swings | 0 | 1 | 2 | 3 |
| 5. Insomnia | 0 | 1 | 2 | 3 |
| 6. Heavy bleeding two weeks/month | 0 | 1 | 2 | 3 |
| 7. Sweating throughout day | 0 | 1 | 2 | 3 |
| 8. Dryness of skin, hair, and vagina | 0 | 1 | 2 | 3 |
| 9. Painful intercourse | 0 | 1 | 2 | 3 |
| 10. Vaginal pain | 0 | 1 | 2 | 3 |
| 11. Vaginal itching | 0 | 1 | 2 | 3 |
| 12. Osteoporosis (bone loss) | 0 | 1 | 2 | 3 |

PART 10

1. Muscle spasms.....	0	1	2	3	6. Stiff all over.....	0	1	2	3
2. Tightness in shoulder muscles.....	0	1	2	3	7. Stiff in morning.....	0	1	2	3
3. Muscle cramps.....	0	1	2	3	8. Unable to sit straight.....	0	1	2	3
4. Pain in arms, hands.....	0	1	2	3	9. Pain in neck and/or shoulders.....	0	1	2	3
5. Leg cramps at nights.....	0	1	2	3	10. Back pain.....	0	1	2	3
					11. Joint pain.....	0	1	2	3

PART 11

1. Head feels heavy.....	0	1	2	3	10. Loss of grip strength.....	0	1	2	3
2. Light headedness/fainting.....	0	1	2	3	11. Tingling pain sensation.....	0	1	2	3
3. Loss of balance.....	0	1	2	3	12. Convulsions.....	NO			YES
4. Dizziness.....	0	1	2	3	13. Uncoordination.....	0	1	2	3
5. Ringing/buzzing in ears.....	0	1	2	3	14. Nervousness.....	0	1	2	3
6. Trembling hands.....	0	1	2	3	15. Accident prone.....	NO			YES
7. Loss of feeling in hands and/or feet (toes).....	0	1	2	3	16. Loss of muscle tone.....	NO			YES
8. Exhaustion on slightest effort.....	0	1	2	3	17. Need for 10-12 hours sleep.....	NO			YES
9. Limbs feel too heavy to hold up.....	0	1	2	3	18. Have had shingles.....	NO			YES

PART 12**SECTION A: Over the last year, I have experienced:**

1. Becoming forgetful.....	0	1	2	3
2. Lapses in memory.....	0	1	2	3
3. Becoming less attentive.....	0	1	2	3
4. Less interest in normal activities.....	0	1	2	3
5. Feeling less sharp.....	0	1	2	3
6. Difficulty remembering people's names.....	0	1	2	3
7. Difficulty making decisions.....	0	1	2	3
8. Problems finding the right words to communicate.....	0	1	2	3
9. Difficulty solving routine problems.....	0	1	2	3
10. Difficulty learning new things.....	0	1	2	3
11. Problems writing, reading, or organizing thoughts.....	0	1	2	3
12. Difficulty following instructions.....	0	1	2	3

SECTION B: I experience:

1. Lack of interest in normal activities.....	0	1	2	3
2. Loss of energy.....	0	1	2	3
3. Oversleeping or sleepiness.....	0	1	2	3
4. Sense of sadness for no apparent reason.....	0	1	2	3
5. Increased appetite, especially for carbohydrates.....	0	1	2	3
6. Fatigue.....	0	1	2	3
7. Symptoms that usually get worse in the winter.....	0	1	2	3
8. Weight gain or weight loss.....	0	1	2	3
9. Difficulty concentrating and processing information, especially in the afternoon.....	0	1	2	3
10. Diminished sexual desire.....	0	1	2	3

SECTION C: I frequently

1. Feel tense and have trouble relaxing.....	0	1	2	3
2. Have headaches and other aches and pains.....	0	1	2	3
3. Get crabby or grouchy.....	0	1	2	3
4. Have trouble falling asleep or staying asleep.....	0	1	2	3
5. Sweat and have hot flashes in anticipation of events.....	0	1	2	3
6. Feel irritable or short tempered.....	0	1	2	3
7. Have trouble letting go of things.....	0	1	2	3
8. Get angry for no apparent reason.....	0	1	2	3
9. Women only: Get worse symptoms prior to getting my period.....	0	1	2	3

SECTION D: I often:

1. Feel overly active and compelled to do things, like being driven by a motor.....	0	1	2	3
2. Have difficulty relaxing and unwinding when I have time to myself.....	0	1	2	3
3. Misplace and have difficulty finding things.....	0	1	2	3
4. Crave caffeine and stimulants to keep me going.....	0	1	2	3
5. Delay getting started when I have a task or work that requires a lot of thought.....	0	1	2	3
6. Get easily distracted by activity or noise around me.....	0	1	2	3
7. Have difficulty keeping my attention when doing boring and repetitive work.....	0	1	2	3
8. Fidget or squirm with my hands and feet when I have to sit down for a long time.....	0	1	2	3
9. Leave my seat in meetings or other situations in which I am expected to remain seated.....	0	1	2	3
10. Have problems remembering appointments or obligations.....	0	1	2	3
11. Have difficulty concentrating on what people say to me, even when they are speaking directly to me.....	0	1	2	3
12. Move around and kick in my sleep.....	0	1	2	3

SECTION E: I experience:

1. Waking up frequently during the night with difficulty returning to sleep.....	0	1	2	3
2. Looking forward to catching up on my sleep on the weekends.....	0	1	2	3
3. Taking more than 30 minutes to fall asleep at night.....	0	1	2	3
4. Stomach problems or nausea.....	0	1	2	3
5. Waking up repeatedly throughout the night.....	0	1	2	3
6. Waking up groggy and not well rested.....	0	1	2	3
7. Preferring to go to sleep later than midnight and waking up late, after 10:00 a.m.....	0	1	2	3
8. Preferring an early bedtime – going to sleep between 7 p.m. and 9 p.m. and waking up early, around 5:00 a.m.....	0	1	2	3
9. Jet lag.....	0	1	2	3
10. Difficulty turning off my thoughts when I lay down to sleep.....	0	1	2	3

PATIENT INFORMED CONSENT

This Informed Consent is required by Minnesota Statute 147E in order that you, the patient, are aware of the nature of Stephani Waldron-Trapp, ND's practice in naturopathic medicine. The Minnesota Board of Medical Practice has required that each individual seeing Stephani Waldron-Trapp, ND read this form and sign it prior to consultation or treatment.

I, _____, UNDERSTAND THAT:

1. Stephani Waldron-Trapp, ND is fully credentialed and registered to practice naturopathic medicine in the State of Minnesota, pursuant to Minnesota Statute 147E. Her active registration number is 1016.
2. Dr. Waldron-Trapp received her four-year naturopathic medical training at University of Bridgeport College of Naturopathic Medicine, Connecticut, and graduated in 2005.
3. Dr. Waldron-Trapp passed all Naturopathic Physicians Licensing Examinations given by the North American Board of Naturopathic Examiners and received her Vermont license in 2005 to practice as a naturopathic doctor. She maintains this license as well.
4. Dr. Waldron-Trapp, to the best of her ability, will present treatment facts and options accurately, and will make recommendations according to standards of good naturopathic medical practice.
5. The scope of practice of a registered naturopathic doctor in the State of Minnesota includes, but is not limited to, the following services: (a) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the federal Food, Drug, and Cosmetic Act, glandular, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease; (b) performing or ordering physical examinations and physiological functions tests; (c) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA); (d) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results; (e) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; (f) prescribing or performing naturopathic physical medicine; and (g) admitting patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.
6. A registered naturopathic doctor is **not** allowed to: (a) administer therapeutic ionizing radiation or radioactive substances; (b) administer general or spinal anesthesia; (c) prescribe, dispense, or administer legend drugs or controlled substances including chemotherapeutic substances; (d) perform or induce abortions; or (e) perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue.
7. A registered naturopathic doctor is **not** allowed to practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietitian, nutritionist, or any other health care professional, unless the registered naturopathic doctor also holds the appropriate license or registration for the health care practice profession.
8. Potential risks include allergic reactions to prescribed herbs and supplements and side effects of natural medications.
9. All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.
10. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Stephani Waldron-Trapp, ND or any of her personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understand the statements above.

Patient Signature: _____

Date: _____