Flying Crane Wellness Studio

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Medical History Form for Adults Today's Date:_____
Please fill this form out as completely as possible.

Full legal name:_____
Gender: _____
Date of Birth: _____

Address:_____
Phone Numbers: Home: _____ Mobile:_____
Email address: _____

Preferred method of contact? _____
May I leave messages?_____

Marital status _____ Spouse/ partner's full name_____

Members of household	Age	Relationship
1)		
2)		
3)		
4)		

Who should be contacted in case of an emergency? _____
_____
Occupation _____ Hours per week _____

Are you currently receiving healthcare?
If yes, where or from whom? _____
_____
Conventional medical diagnosis: _____
_____
Do you have any other current medical/physical conditions or contagious illness I should be aware of?_____
_____
_____
_____
If you are not currently receiving healthcare, when and where did you last receive medical or health care?_____
_____
What was the reason?_____
_____

List current pharmaceutical prescriptions or over-the-counter medications: _____
_____
_____
_____
_____

Do you currently use any of the following (check or circle):

Antacids	Hormone replacement
Antibiotics	Laxatives
Appetite suppressants	Sleeping pills
Birth Control Pills	Steroids
Cortisone	Thyroid medication
	Tranquilizers

Identify any other medications you have used in the past and why: _____
_____
_____

List current supplements (vitamins, herbs, homeopathics, etc.):
_____
_____
_____
_____
_____

Identify any allergies or sensitivity to medications or other substances (foods, chemicals, pollens, etc.) known to you:_____
_____
_____
_____
_____

Are you strongly sensitive to any of the following (check or circle):

Cigarette smoke	Odors in general
Dust, mold	Perfume
Exhaust, fumes	Pollen
Getting feet wet	Noise

Other (please specify):_____
_____

Please list the health concerns you would like to discuss. Please list in order of importance:

1.
2.
3.
4.
5.
6.

Context of Care Overview

Why did you choose to come to a naturopath?_____
_____
_____

What do you know about naturopathic medicine?_____
_____

What expectations do you have from this initial visit?_____
_____

What long-term expectations do you have?_____
_____

What is your level of commitment to addressing the underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from zero to 100% commitment):
0% 10 20 30 40 50 60 70 80 90 100%

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health or in adhering to the therapeutic protocols that I will be recommending to you?
_____
_____
_____

Do you get regular exercise? Y N
If yes, what kind? _____
How often? _____

Do you spend time outside? Y N

Do you average 6 to 8 hours of sleep? Y N Awaken rested? Y N
Do you have difficulty falling asleep? Y N
Do you wear socks to bed? Y N
Do you use an electric blanket? Y N
Do you grind your teeth at night? Y N
Do you snore? Y N
Do you remember your dreams? Y N
Have you had any recurring dreams or dreams that have made a strong impression on you?
Please elaborate:_____
_____
Do you nap? Y N
When during the day is your energy best? _____Worst? _____
Do you have a dip in energy at a regular time of the day or night? Y N
When? _____

Do you enjoy your work? Y N Take vacations? Y N
Do you watch television? Y N How many hours per day?_____
Do you read? Y N How many hours per day?_____
What pets do you have? _____
Do you have a religious/ spiritual practice?_____

Height _____ Weight _____ Weight 1 year ago_____
Maximum weight _____ When? _____

Do you diet? _____
Do you eat three meals a day? Y N
Do you eat out often? Y N

Do you drink coffee? Y N Black/green tea? Y N Soft drinks? Y N
Alcohol? Y N How much of each? _____
_____
Do you watch your sugar intake? Y N
Do you add salt to your food? Y N

Typical Food Intake:

Breakfast

Lunch

Dinner

Snacks

To drink

Do you smoke or use snuff/ chewing tobacco? Y N In the past? Y N
Do you use recreational drugs? Y N In the past? Y N

Past Medical and Family History

Birth and developmental history:
Did your mother have any problems during her pregnancy with you? Y N
Did she have any problems during labor and your delivery? Y N
Was there any delay in your walking or talking? Y N
Was there any delay or problem with your baby or adult teeth? Y N
Was there any prolonged bedwetting? Y N

Childhood illnesses (please check or circle all that you've had):

Chickenpox	Rubella
Measles	Scarlet Fever
Mumps	Whooping cough
Polio	Rheumatic Fever

Other (please list): _____

Immunizations (please check or circle all that you've had):

DPT	Polio
Flu	Smallpox
Hepatitis	Tetanus
MMR	TB

Other (please list): _____
Have you ever had a reaction to a vaccine/ immunization? If so, please elaborate:
_____
_____

Trauma history:
List any major accidents, head injuries, falls, blows or loss of consciousness that you have experienced. Please include dates. _____
_____
_____
_____

Hospitalizations:
Please list any hospitalizations, surgeries or outpatient procedures. Include dates.
_____
_____
_____
_____

Family History:

Relation	*Living*	*Dead*	*Age*	*Major illness or cause of death*
Mother				
Father				
Brother(s):				
Sister(s):				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				

Please check or circle any of the following that have occurred in your blood relatives:

Alcoholism	Diabetes	Osteoporosis
Allergies	Drug abuse	Seizures/ epilepsy
Anemia	Glaucoma	Stroke
Arthritis	Heart disease	Suicide
Asthma/hay fever/ hives	Hypertension	Tuberculosis
Cancer	Kidney disease	
Depression/mental illness	Neurological disorders	

Please indicate any other relevant family history: _____
_____
_____

Review of Systems
Please check or circle the conditions that apply, either now or in the past

Mental/ Emotional

Depression	Anxiety
Suicidal	Anger/ Irritability
Eating Disorder	Fear/ Panic
Hallucinations	

Skin

Rough, dry skin	Night sweats
Itching/ hives	Shingles/ herpes
Rashes	Cysts
Eczema	Moles
Psoriasis	Acne/ boils
Hair loss, where:	Nail changes
Excessive sweating	Discoloration (which color?)
Strong odor of perspiration	Slow wound healing/ ulcerations
Easy bruising	Contact allergies/ sensitivities

Head and Neck

Migraines	Neck pain or stiffness
Headaches	Jaw problems/ TMJ
Visual disturbances	Lumps

Ringing in the ears
Cluster headaches
Head injury
Facial pain, location
Facial neuralgia, location
Twitching, location
Swollen glands, location
Goiter

Mouth, Teeth and Throat

Bleeding gums
Gum infections
Fever blisters
Canker sores
Excessive salivation
Many dental cavities
Loss of teeth
Bad breath
Enlarged tonsils
Peculiar taste (please describe):
Cracking in jaw
Cracked lips
Cracks on tongue
Sore/ enlarged tongue
Sensitive teeth
Teeth grinding
Frequent sore throats
Persistent hoarseness

Eyes

Eye pain/ strain
Spots in eyes
Halos or lights
Poor vision
Night blindness
Double vision
Color blindness
Sensitivity to light/ sunshine
Cataracts
Glaucoma
Styes
Sensation of sand in eyes
Dry eyes
Itchy eyes
Redness
Tearing
Conjunctivitis

Ears

Impaired Hearing
Chronic ear infections
Earaches/ pain in ears
Discharge from ears
Itching in ears
Ringing/ noises in ears
Dizziness

Nose and Sinuses

Frequent colds
Chronic stuffiness/ congestion
Sinus infections
Hayfever
Sneezing
Problems breathing: Day Night
Snoring
Loss of smell
Nose bleeds
Eruptions/ sores

Respiratory

Asthma
Wheezing
Chronic cough
Frequent chest colds
Bronchitis
Pleurisy
Shortness of breath
Difficulty breathing with exertion
Difficulty breathing when walking
Difficulty breathing when climbing stairs
Difficulty breathing when lying down
Pain on breathing

Pneumonia
Emphysema
Tuberculosis
Snoring
Coughing up mucus
Coughing up blood
Pain on breathing

Cardiovascular

Rheumatic fever
High blood pressure
Low blood pressure
Palpitations
Murmurs
Angina
Heart disease (please specify):
Fainting
Swelling of ankles or legs
Phlebitis
Leg pain unrelated to injury
Chest pain with exertion
Chest pain at rest

Circulatory

Anemia
Cold hands and feet
Deep leg pain
Easy bruising or bleeding (please specify):
Other (please specify):
Varicose veins
Thrombophlebitis
Stroke

Musculoskeletal

Arthritis
Joint pain or stiffness
Polio
Weakness (please specify):
Broken bones (please specify):
Muscle spasms or cramps (please specify):
Sciatica
Osteoporosis

Neurological

Seizures
Dizziness or vertigo
Loss of balance
Fainting
Numbness or tingling (please specify):
Paralysis (please specify):
Muscle weakness (please specify):
Memory loss
Discomfort with heights
Motion/ car/ sea sickness
Easily stressed

Immune

Chronic Fatigue Syndrome
Acquired Immune Deficiency Syndrome
Chronic infections
Chronically swollen glands (where?):
Autoimmune disease (please specify):

Endocrine

Diabetes
Hypoglycemia
Hypo/ Hyperthyroid
Fatigue
Seasonal depression
Heat or cold intolerance

Gastrointestinal

Heartburn	Indigestion
Bloating	Nausea
Constipation	Vomiting
Change in appetite	Gallbladder disease
Liver Disease	Hemorrhoids
Diarrhea	Blood/ mucus in stool
Alternating constipation/ diarrhea	Irritable Bowel Disease

Change in usual pattern of bowel movements Y N
Do you have a daily bowel movement? Y N

Urinary Tract

Pain w/ urination	Frequent UTIs
Incontinence	Urgency
Kidney stones	Blood in urine

Frequent urination Day Night

Female Only

Age of first period?
Usual length of periods?
Are your periods regular?
Number of pregnancies?
Number of live births?
Sexually active

Menstrual cramps/ pain	Heavy bleeding
Abnormal Pap smear	Regular Mammograms
PMS	Hormone use or BCP
Menopause	STD
Hot flashes	Hair on face

Male Only

Testicular Pain or swelling	Sexually active
STD	
Last prostate exam/ PSA evaluation	

Thank you for your time and effort. I look forward to serving you to the best of my ability. Is there anything else you would like to add or comment on?

_____
_____
_____
_____
_____
_____
_____
_____