All Information You Provide In This Questionnaire is Completely Confidential

- **How did you hear of Dr. Heller? ____ ***

Name of Patient ______________________________ Date of Birth ______ / ______ / ______

Home Phone ( ) ____________ Work Phone ( ) ______________ Other Phone ( ) ______________

Address ______________________________ Town/City ________________State ______ Zip__________

Relationship Status: Single / Married / Separated / Divorced / Widowed / Widower / Committed Relationship

Most Important Reason for Making This Appointment____

Other Health Concerns in order of importance to you

2.____________________________________ 4. ______________________________________

3. ____________________________________ 5. ______________________________________

Have you ever had any of the following?

___ HIV Infection
___ Cancer
___ Frequent/Prolonged Antibiotics
___ Frequent/Prolonged Steroid Use
___ Attempted Suicide
___ Psychiatric Hospitalization
___ Severe Depression
___ Addiction (Food, Drugs, Alcohol)
___ Abuse (Sexual, spousal, child)

Any other significant medical history, or Important Details of Above ______________________________

____

____

Hospitalizations: (date and type of illness/procedure)

1.____

2. ____

3. ____

Allergies to Food/ Drugs/ Other Substances (Please describe)

____

____

Are you currently under the care of any other health care practitioner? For What?

When was your last general medical exam that included routine blood work?

Please circle any of the following you have experienced in the last two years: Death of spouse / Divorce / Marital Separation / Jail Term / Death of close family member / Personal Injury or Illness / Getting Married / Being Fired From Work / Retirement / Change in Health of Family Member / Being Laid Off / Change in financial condition / Change in Job Status / Accused of crime / Convicted of crime / Lawsuit

In the past ten years, have you been on a diet or natural health program that helped you to feel great?

Has there been an illness or event in your life from which you feel there is still an undue influence?

Have you ever been in a serious car accident, had a serious head injury, or had other severe physical trauma?

Would you rate your attitude towards natural medicine as:

-Enthusiastic - Interested - I'll wait and see -Cautious -Doubt it works

Please circle any of these that are current or recent symptoms – Add "C" for current problems

Skin: *Dryness* – Clammy – Itching – Rashes – Bumps – Dandruff – *Recent change in skin texture* – *Recent Hair Loss* – *Recent change in hair texture/quality* - Other

Head: Headaches – TMJ – Dizziness – Fainting – Jaw Pain – Facial Pain – Facial Swelling – Migraines - Other

Eyes: Bags / Circles Under Eyes – Pain – Dryness – Tearing – Itching – Styes – Recent Vision Changes - Other

Ears: Itching – Discharge – change in hearing – ringing in ears – ear infections – Other

Nose: Congestion – Sneezing – Pain – Post-Nasal Drip – Hayfever – Bad Smells Occur – Sensitive to Odors – Sinus Infections – Other

Mouth: Sore Mouth – *Enlarged Tongue* – Canker Sores – Dryness – Cold Sores (Herpes) – Change in Thirst – Bad Taste in Mouth – Other

Throat/Neck: Sore or enlarged glands - Throat Pain - *Difficulty Swallowing* - *Change in Voice* - Other

Respiratory: Pneumonia – Bronchitis – Cough - Wheezing - Shortness of Breath – Difficulty Breathing - Other

Cardiovascular: Palpitations - Racing Heart - High or Low Blood Pressure - Cold Hands or Feet - Varicose Veins
Leg Pain/Cramps - Ankle Swelling - High Cholesterol - Other

Digestion: *Constipation* – Diarrhea – Loose Stools – Rectal Itching – Hemorrhoids – Blood or mucus in stools – Ulcer – Heartburn – Reflux – Bloating – Excessive or Unpleasant Gas – Nausea – Vomiting – Cramping - Pain – other

Urinary Painful Urination - Incontinence/Dribbling - Blood In Urine - Frequent Urination - Bladder Infections - Kidney Stones - Other

Neuro/Musculo/Skeletal: Neck or Back Pain - *Muscle,* Joint, or Bone *Pain* - Stiffness - Joint Swelling - Muscle Weakness or Tremor - Numbness or Tingling – Loss of Balance – Seizures - Other

Mental/Emotional: Depression – Anxiety – Panic - Mood Difficulties – Often Irritable – Easily Irritated – Often Angry
Easily Angered – Cry Easily – Learning Difficulties - *Poor Concentration* - *Poor Memory* - Other

Sleep: Difficulty Falling Asleep – Difficulty Staying Asleep - Nightmares - Sleep Apnea – Snoring - Other

General: *Fatigue* - *Weight Changes* - *Feel Hot or Cold* - Change in Appetite or Thirst - Other

Perspiration: Too much – Very Little – Cold Sweats – Overheated easily – Night Sweats
Location of perspiration____

Women: Do You Use Birth Control Pill? When Was Your Most Recent Routine GYN exam?
Have you ever had an Abnormal Pap Smear? At What Age Did Your Period Begin? Regular Periods? Yes/No
Date of Last Period? # of Pregnancies _________ # of Miscarriages _________ # of Abortions ___________
# of Childbirths __________ Complications in Childbirth Impaired Fertility Age at Menopause_________
Have you had a Hysterectomy? If so, total or partial (ovaries remain) Night Sweats - Hot Flashes
Do any of the following accompany your period: Spotting – Cramps/Pain - PMS - Excessive or Irregular Bleeding
Frequent Yeast Infections - Endometriosis – Fibroids - Vaginal Discharge - Vaginal Dryness - *Change in Sex Drive*
Painful Intercourse - Sexually Transmitted Disease - History of Sexual Abuse - Other

Men: Change in Urine Stream – Pain or Lump in Scrotum - Discharge from Penis - Painful Intercourse
Difficulty with Erections - *Change in Sex Drive* - Impaired Fertility - Sexually Transmitted Disease
History of Sexual Abuse – Other

Details of Above:

Lifestyle Factors:

Tobacco________________________

Alcohol________________________

Coffee/Tea______________________

Junk Food/Sweets________________

Hours Television/week____________

Recreational Drug Use ____________

# of hours worked/week__________

hours sleep/night_______________

Take vacations?__________________

Have children? _________________

If yes, what ages ______________

Have pets? _____________________

If yes, what __________________

Hobbies? _____________________

New Paint/Carpeting/Cabinetry within past year? Yes / No

Do you have any religious or spiritual affiliation? Yes / No / N/A

Prescription or OTC Medications

1.______________________________

2.______________________________

3.______________________________

4.______________________________

Nutritional/Herbal/Other Supplements

Multivitamin____________________

Other__________________________

Other__________________________

Other__________________________

Please rate the following on a scale of 1 – 10. 1 = bad, need help in this area; 10 = excellent, doing everything I should be doing in this area:

- Diet:
- Sleep:
- Exercise:
- Drinking Water:
- Enjoy Relationships/Home Life:
- Enjoy Work:
- Am At A Healthy Weight:
- Typical Energy Level:
- Generally Feeling Good:
- Understand What Nutrient Supplements Are Best For Me

Give your best possible answer to these questions; if you know your Myers-Briggs personality type (four letters) enter it here:

Being around lots of people
gives me more energy /
drains my energy

I need time alone to think and
"recharge my batteries"
- rarely -sometimes -often - a LOT

I prefer to be busy and have a lot
going on
-Yes - Sometimes -No

I think things are:
-pretty much as they seem
-not as they seem

People think I'm
-spacey , thoughtful
-concrete, down to earth

I tend to be more:
- rational - emotional

I am by nature
- neat and punctual
- disorganized and habitually tardy

I think the best way to solve problems is:
-thinking things through and evaluating the situation rationally

-checking how I and others feel about the situation

I prefer:
- leaving things open-ended
- having things be clearly defined

I am more
-adventurous -the stay at home type

I would like to be more:
-highly motivated - easy-going

Other people think I'm
- highly motivated -easy-going

I tend to be
- warm and need fresh air
- cold and sensitive to drafts
- neutral but sensitive to drafts

The following climates / environmental conditions have an effect on me (please note whether positive or negative)

- cold and damp (Seattle)
- hot and damp (east coast summer)
- rainy / cloudy / dark (winter)
- dry (desert)
- cold (any kind of cold weather)
- seashore / ocean
- thunderstorms (during / before)

My best time(s) of day is / are:

My worst time(s) of day is / are:

I tend towards:
- constipation - loose stool

T or F
- my food feels like a lump in stomach after eating
- I have a great appetite and can usually eat more

Family Medical History
(please indicate which relations have had these conditions)

- Depression
- Mental/Psychiatric Illness
- Alcoholism
- Substance Abuse
- Diabetes
- Obesity
- High Blood Pressure
- High Cholesterol
- Cancer

-Are there any other conditions that run in your family?

- Thyroid Disease
- Autoimmune Disease
- Cancer
- Alzheimers
- Premature Menopause
- Heart Attack/Stroke
- Other Heart Disease
- Arthritis
- Allergies
- Asthma
- Sickle Cell/Thalassemia

For the following questions:
Circle O if the answer is "often";
Circle S if the answer is "sometimes";
Circle N if the answer is "never"
Do you:

- Get irritable or shaky when I don't eat on time O/S/N
- Energy plummets mid-morning and/or mid-afternoon O/S/N
- Feel Foggy or Cloudy Headed? O/S/N
- Wake unrefreshed after adequate sleep? O/S/N
- Feel "heavy" in head/ body/ or limbs? O/S/N
- Have cravings for sweets/ bread/ pasta/ potatoes/ etc? O/S/N
- Get sleepy after meals? O/S/N

How many times have you been on antibiotics within the past two years?

I am looking for: - Symptom Relief/Quick Fix - Find out the cause of my conditions
-Long term prevention/Optimal Health (avoid cancer, heart disease, alzheimer's, autoimmune disease, etc)

Please take a moment to list any other health concerns you have, even if you're not sure they are related to your main health issues. Thank You. The completeness of this entire form is an important step on the road back to optimal health. Please include any conditions or diseases you have, or have been diagnosed with.

Dr. Daniel Heller
Naturopathic Physician