NORTHWESTERN CLINIC OF NATUROPATHIC MEDICINE

HEALTH QUESTIONNAIRE: *please fill out BOTH SIDES completely and print legibly in ink*

Name: ____ Date of Birth: ___/___/_____ Sex: M / F

PRESENT HEALTH CONCERNS

Health Concerns: *in order of importance to you*	**Prior diagnosis of this concern?** *please list*
1.	
2.	
3.	
4.	

Goals for today?____

Have you ever consulted a Naturopathic Physician before? ❍ No ❍ Yes → Who?___________________

MEDICATIONS

Prescription & OTC Medications	Dosages	Prescription & OTC Medications	Dosages
Vitamins, Supplements, Herbs, Homeopathics	**Dosages**	**Vitamins, Supplements, Herbs, Homeopathics**	**Dosages**

ANY STRICT AVERSION TO TAKING THE FOLLOWING ***(Check all that apply)***

❍ Capsules ❍ Tablets ❍ Alcohol tinctures ❍ Glycerite tinctures ❍ Powders ❍ Tea

Allergies to medications (please specify)

Other severe or life-threatening allergies

HEALTH HABITS & OCCUPATIONAL HAZARDS

HEALTH HABITS: check all that apply currently or in past and describe amount	Do you eat organic foods?	Are you sensitive to:	**OCCUPATIONAL:** Does your work expose you to the following:
❍ Drugs________________________ Year Quit______	❍ Always	❍ Sugar	❍ Stress
❍ Tobacco______________________ Year Quit______	❍ Often	❍ Caffeine	❍ Heavy Lifting
❍ Alcohol____	❍ Sometimes	❍ Chemicals	❍ Hazardous Substances
❍ Caffeine____	❍ Never	❍ Perfumes	❍ Computer
❍ Soft Drinks		❍ Medicines	❍ Other:

Do you exclude any foods from your diet?	❍ No ❍ Yes → Describe
Do you exercise regularly?	❍ No ❍ Yes → Describe
Additional Comments:	

SERIOUS INJURIES & HOSPITAL ADMISSIONS *(not including pregnancies)*

Year	Illness, Operation or Injury	Year	Illness, Operation or Injury

Date of last physical/annual exam ______________________ Date of last blood tests: _________________

Please fill out the next page →