HH Naturopathic and Acupuncture Center

PLEASE WRITE LEGIBLY

Patient Name:_____

Last Name First Name Middle Initial

What is your preferred name? (Nick name, Chosen name, etc)_____
DOB (required) _____SSN:_____Blood type:_____
Number of children:_____ Names & ages_____
Height:_____ Weight:_____ Gender: □F □ M Occupation:_____
□ Single □ Married □ Significant other □ Divorced □ Widowed □ Separated

Referred by: _____
Family Physician's Name and contact number:_____

Home address:_____
City:_____State:_____Zip code:_____
Email address:_____
Phone:

1. □ cell □home □work:_____Confidential voice mail OK? □Yes □No
2. □ cell □home □work:_____Confidential voice mail OK? □Yes □No

List your current health concerns:

Prioritize by listing the health concerns in order of importance.
1._____2._____
3._____4._____

Complete the following section for your top 3 medical concerns.

#1 Concern:_____Date of onset:_____
Describe_____
_____
Any medications/ surgery/ treatment tried and results:_____
_____
Associated trauma, injury, personal or family history:_____
_____
How do you think this problem developed in your life?_____

Office use only:

_____

#2 Concern:_____Date of onset:_____

Describe_____

_____

Any medications/ surgery/ treatment tried and results:_____

_____

Associated trauma, injury, personal or family history:_____

_____

How do you think this problem developed in your life?_____

_____

Office use only:

#3 Concern:_____Date of onset:_____

Describe_____

_____

Any medications/ surgery/ treatment tried and results:_____

_____

Associated trauma, injury, personal or family history:_____

_____

How do you think this problem developed in your life?_____

_____

Office use only:

General information:

Have you seen and work with naturopathic physician before ? □Yes □No

Are you currently seeing one? □ Yes □No Doctor's name:_____

Do you have any other healthcare professionals (i.e acupuncturist, massage therapist, counselor) □Yes □No

What are the most significant measures that you have taken to improve your state of health?_____

_____

Personal Health History:

Allergies: _____

Surgeries and hospitalization:_____

_____

Medications: List all medications, over-the counter medications, vitamins, or other supplements you are taking

Name of Medications and supplements	Dose	Frequency Taken

Medical Conditions: Please check and name who was affected (self, mother, father, grandparents, sisters, brothers, children)

□AIDs/HIV_____ □Alzheimer's/Dementia__ □Anxiety_____

□Adrenal disorder_____ _____ □Arthritis/joint disorder___

□Alcoholism_____ □Anemia_____ □Asthma_____

□Cancer _____
□Childhood trauma_____
□COPD_____
□Depression_____
□Diabetes Mellitus_____
□Digestive problem_____
□Drug problems_____
□Eczema
□Gout_____
□Heart disease_____
□Hyperlipidemia_____
□Hypertension_____
□Hypoglycemia_____
□Inflammatorybowel disease_____
□Irritable bowel syndrome _____
□Kidney disease_____
□Liver disease_____
□Mental illness_____
□Migraines_____
□Obesity_____
□Psoriasis_____
□PMS_____
□Seizures_____
□Sexual abuse_____
□Suicide_____
□Stroke_____
□STD_____
□Thyroid disease_____
□TB_____
□Ulcer_____
□Other:_____

□Adopted - family hx unknown

Tobacco use:
□Never smoked □Former smoker □ Passive smoke exposure (second hand)
□Current smoker □Other
Start date: _____End date:_____
Type of tobacco used □Cigarette □Cigars □Pipe □Chew □Snuff
Packs/day: _____Years
Quit date (if applicable):_____
If you are a current tobacco user: Are you ready to quit □Yes □No

Do you drink alcohol?
If yes, how many of the following do you have per week?
Drinks/week: Glasses of Wine_____Cans of Beer_____Shots of Liquor_____

Sexually Active: □Yes □No
Birthconrtol/Protection method:_____
Do you have any children □ Yes □No If so, name and ages:
_____

Do you exercise regularly? □Yes □No(type and frequency) _____
_____

Do you have any dietary restrictions or food intolerances? □Yes □No If so what?
_____

Menstrual/Reproductive History (Women only)
Menses Age period begin? _____ Date of last period:_____
Regular period? □Yes □ No □Sometimes
How many days between each cycle? (length of time between start of one period to the start of the next period) _____

Flow: □Heavy □Medium □Light Duration of days: _____
Spotting? □Yes □No Mid cycle: □Yes □No Instead of Period: □Yes □No
Bloating? □Yes □No Cyclic premenstrual weight gain: □Yes □No How much? _____lb
Cramps? □Yes □No Duration:_____days. Intensity: □Mild □Moderate □Severe
PMS? □Yes □No Describe:_____

Pregnancy
Current pregnancy? □Yes □No Planning? Yes No When:_____
Prior pregnancies:#_____Births:#_____Miscarriages: #_____Abortions:#_____
C-section:#_____
Complications? □Yes □No Describe:_____
Type of birth control:_____
Ever used birth control pills? □Yes □No How long/when?_____

Hormones
Menopausal: □ Yes □No Ovaries Present: □Yes □No Uterus present: □Yes □ No
Date Uterus or Ovaries were removed:_____
Hot flashes: □Yes □No Any Rx:_____Onset:_____
Frequency:_____ times per day/week for _____minutes.
Intensity: □Mild □ Moderate □Severe
Painful intercourse: □Yes □No Vaginal dryness: □Yes □No

Breast Exam:
Breast pain/lumps? Yes No Breast discharge? Yes No
Date of last mammogram: _____Results:_____
Do you do self-breast examination? □Yes □No How often? _____

Pelvic Exam:
Date of last pelvic exam: _____Reason:_____
Date of last PAP:_____ Results:_____
Previously abnormal PAP Yes No Date:_____Results:_____Therapy:_____
Recurring vaginal yeast infections? Yes No Onset:_____Frequency:_____

Reproductive History: (Male Only)
Hernias: □Yes □No Testicular Mass: □ Yes □No Sexual difficulty: □Yes □No

Review of System

Constitutional: ☐Good general health ☐Fever ☐Chills ☐Malaise/fatigue/weakness ☐Sweating ☐Recent weight changes	**Gastrointestinal:** ☐Nausea/vomiting ☐Abdominal pain ☐Rectal bleeding ☐Indigestion/heartburn/reflux ☐Constipation ☐Diarrhea ☐Bloating ☐How many bowel movement per day:	**Integumentary/Skin:** ☐Rash ☐Itching ☐Abnormal nails ☐Dry/discolored skin
Head, Ears, Nose, Throat: ☐Headache ☐Hearing loss ☐Ringing in ears ☐Ear pain ☐Ear discharge ☐Nose bleeds ☐Congestion ☐Migraine headaches ☐Sore throat/voice changes	**Genitourinary:** ☐Painful urination ☐Blood in the urine ☐Frequency ☐Incontinence ☐Flank pain ☐Kidney stone ☐Sexual problems ☐Testicule/Ovary pain ☐Infertility ☐Menstrual problem	**Allergic/immunologic** ☐Food allergy ☐Frequent infection ☐Hay fever ☐Chemical sensitivity
Eyes ☐Wear glasses/ contacts ☐Blurred/double vision ☐Eye disease or injury ☐Eye pain/dryness ☐Eye discharge	**Musculoskeletal** ☐Muscle pain ☐Muscle spasm ☐Neck pain ☐Back pain ☐Joint pain ☐Trouble walking/falls	**Neurologic** ☐Dizziness/fainting ☐Loss of memory ☐Sensory change ☐Speech change ☐Tremor/seizures ☐Numbness/tingling
Cardiovascular: ☐Chest pain ☐Palpitation ☐Heart trouble ☐Swelling hands/feet ☐Lightheaded ☐Blood clots	**Endocrine:** ☐Excessive thirst/urination ☐Excessive hunger ☐Hair loss ☐Cold hands and feet ☐Cold and heat intolerance ☐Hormone problems	**Psychiatric:** ☐Depression ☐Insomnia ☐Hallucination ☐Nervous/anxious ☐Substance abuse ☐Anxiety/pain attack
Respiratory: ☐Shortness of breath ☐Cough ☐Coughing up blood ☐Wheezing/Asthma ☐Bad breath ☐Sputum production	**Hematologic/lymphatic:** ☐Anemia ☐Bruise easily ☐Slow to heal ☐Enlarged glands	

Naturopathic Medicine Disclosure and Consent

I, (first and last name) _____, hereby request and consent to accept naturopathic and /or homeopathic wellness consultation from Sunhee Williams, Licensed as a Naturopathic Physician in the state of Washington (NT60121426) and Certified Nutrition Specialist in IL , the state of Illinois does not yet offer licensure for naturopathic physicians. Therefore, the Practitioner can not use all treatments approved in all states, nor can she independently be your primary care provider.
It is recommended that you also maintain a relationship with, and, when necessary, seek treatment from a licensed primary care provider. Please initial the following:

_____ I am willfully accepting naturopathic and/or homeopathic wellness consultation from the Practitioner.
_____ I acknowledge that the Practitioner is not acting in any capacity as a licensed physician, but is providing general wellness counseling.
_____I acknowledge that the Practitioner does not diagnose or treat physical or mental ailments, disease of physiological conditions. The Practitioner provides general wellness consultation that may or may not confer health benefit to the individual.
_____ Lab work that is reviewed or requested by the Practitioner is done to assisting in creating a plan to increase health. A medical diagnosis must be sought from an Illinois license healthcare provider.
_____Any supplement, herbal, or homeopathic recommendations may be obtained from any provider. The Practitioner does not claim that such products treat, cure or prevent physical and/or mental ailments or disease. The effects of the products available through the Practitioner have not been evaluated by the Food and Drug Administration.

Acupuncture informed Consent to Treat

I hereby request and consent to the performance of Acupuncture Treatment by Sunhee Williams, Licensed Acupuncturist in IL.

Acupuncture is a safe method of treatment, but on rare occasion it may induce minor bleeding, bruising, numbness or tingling near the needling sites, dizziness and fainting, which are not imposing any risks or danger to the patient's health or life.

By voluntary signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of acupuncture, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Patient signature (or patient representative-indicate relationship if signing for patient)

Date: _____