NAMASTE NATURAL HEALING CENTER, Inc

A heart centered approach to healing mind, body, and spirit

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NAME: ______________________________________ AGE: _________ SEX: M ☐ F ☐ DATE: _________________

MARITAL STATUS: MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ PARTNERSHIP ☐

HOW DID YOU HEAR ABOUT OUR CLINIC? ____

WHEN AND WHERE DID YOU RECEIVE YOUR LAST HEALTH CARE? ____

____

WHAT WAS THE REASON? ____

PLEASE LIST YOUR HEALTH PROBLEMS OR CONCERNS, IN ORDER OF IMPORTANCE TO YOU:

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

FAMILY HISTORY

Please circle Y= YES, currently have N = NO, have never had P = PAST, had in the past but not currently

HAVE YOU OR YOUR FAMILY HAD ANY OF THE FOLLOWING:

				IF YES, PLEASE SPECIFY FAMILY MEMBER AND AGE
ANEMIA	Y	N	P	______________________
ASTHMA, HAYFEVER	Y	N	P	______________________
CANCER	Y	N	P	______________________
DIABETES	Y	N	P	______________________
EPILEPSY	Y	N	P	______________________
HEART DISEASE	Y	N	P	______________________
HIGH BLOOD PRESSURE	Y	N	P	______________________
KIDNEY DISEASE	Y	N	P	______________________
MENTAL ILLNESS	Y	N	P	______________________
NEUROLOGICAL	Y	N	P	______________________
OSTEOPOROSIS	Y	N	P	______________________
STROKE	Y	N	P	______________________
THYROID	Y	N	P	______________________
TUBERCULOSIS	Y	N	P	______________________
VENEREAL DISEASE	Y	N	P	______________________

WERE ANY OF THESE THE CAUSE OF DEATH? IF SO, WHICH FAMILY MEMBER, AND WHAT WAS THEIR AGE AT DEATH?

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CHILDHOOD ILLNESSES:

DIPTHERIA	Y	N	GERMAN MEASLES	Y	N	MEASLES	Y	N
SCARLET FEVER	Y	N	RHEUMATIC FEVER	Y	N	MUMPS	Y	N
MONO	Y	N	EAR INFECTIONS	Y	N	STREP	Y	N
THRUSH	Y	N	DIAPER RASH	Y	N	ECZEMA	Y	N

IMMUNIZATIONS :

POLIO	Y	N	HEPATITIS B	Y	N	RUBELLA	Y	N
PERTUSSIS	Y	N	MEASLES/MUMPS	Y	N	DIPTHERIA	Y	N
TETANUS	Y	N	DATE OF LAST TETANUS SHOT?	___________________________________				
OTHER	_____________		ANY BAD REACTIONS TO IMMUNIZATIONS?	__________________________				

ALLERGIES :

DRUGS ____

FOODS ____

ENVIRONMENTAL ____

DO YOU TAKE ALLERGY SHOTS OR HAVE YOU IN THE PAST ? ____

CURRENT MEDICATIONS :

PRESCRIPTION MEDICATIONS ____

____

____

VITAMINS/HERBS ____

____

____

PAST MEDICAL HISTORY :

HAVE YOU EVER BEEN HOSPITALIZED? Y N

IF YES, WHEN AND WHY? ____

____

HAVE YOU HAD ANY SURGERIES? Y N

IF YES, WHEN AND WHY? ____

____

Y = YES, CURRENTLY HAVE **NO = NEVER HAD** **P = HAD IN PAST**

SKIN

ACNE	Y	N	P	LUMPS	Y	N	P	ITCHING	Y	N	P	MOLES	Y	N	P
COLOR CHANGES	Y	N	P	BOILS	Y	N	P	ECZEMA	Y	N	P	ULCERS	Y	N	P
HIVES	Y	N	P	RASHES	Y	N	P	SCALING	Y	N	P	WARTS	Y	N	P

HEAD

HAIR LOSS	Y	N	P	HEAD INJURY	Y	N	P
HEADACHES	Y	N	P	SKULL FRACTURE	Y	N	P
MIGRAINES	Y	N	P				

EYES

EYE PAIN	Y	N	P	CATARACTS	Y	N	P
DOUBLE VISION	Y	N	P	DRYNESS	Y	N	P
GLASSES/CONTACTS	Y	N	P	GLAUCOMA	Y	N	P
IMPAIRED VISION	Y	N	P	TEARING	Y	N	P

OTHER ___________________________________

EARS

DISCHARGE	Y	N	P	EARACHES	Y	N	P
DIZZINESS	Y	N	P	IMPAIRED HEARING	Y	N	P
RINGING	Y	N	P	TRAUMA TO EAR	Y	N	P

NOSE AND SINUSES

FREQUENT COLDS	Y	N	P	HAY FEVER	Y	N	P
NOSE BLEEDS	Y	N	P	SINUS PAIN	Y	N	P
STUFFINESS	Y	N	P	RUNNY NOSE	Y	N	P

MOUTH AND THROAT

BLEEDING GUMS	Y	N	P	DIFFICULT SWALLOWING	Y	N	P
CAVITIES	Y	N	P	SORE THROATS	Y	N	P
HOARSENESS	Y	N	P	SORE TONGUE	Y	N	P
COLD SORES	Y	N	P	CANKER SORES	Y	N	P

NECK

GOITER	Y	N	P	LUMPS	Y	N	P
PAIN/STIFFNESS	Y	N	P	SWOLLEN GLANDS	Y	N	P
TRAUMA TO NECK	Y	N	P	LOW THYROID	Y	N	P

RESPIRATORY

ASTHMA	Y	N	P	BRONCHITIS	Y	N	P
COUGH	Y	N	P	EMPHYSEMA	Y	N	P
PLEURISY	Y	N	P	PNEUMONIA	Y	N	P
SHORT OF BREATH	Y	N	P	EXCESS MUCUS	Y	N	P
LYING DOWN	Y	N	P	TUBERCULOSIS	Y	N	P
AT NIGHT	Y	N	P	SPITTING BLOOD	Y	N	P
EXERTION	Y	N	P	WHEEZING	Y	N	P

CARDIOVASCULAR

ANGINA	Y	N	P	CHEST PAIN	Y	N	P
DIZZY STANDING	Y	N	P	HIGH BLOOD PRESSURE	Y	N	P
HEART DISEASE	Y	N	P	MURMURS	Y	N	P
IRREGULAR BEATS	Y	N	P	LEG PAIN ON WALKING	Y	N	P
RHEUMATIC FEVER	Y	N	P	SWELLING ANKLES	Y	N	P
HIGH CHOLESTEROL	Y	N	P				

GASTROINTESTINAL

BELCHING OR GAS	Y	N	P	BLOOD IN STOOL	Y	N	P
CHANGE IN APPETITE	Y	N	P	CHANGE IN THIRST	Y	N	P
GALL BLADDER DISEASE	Y	N	P	HEARTBURN	Y	N	P
HEMORRHOIDS	Y	N	P	JAUNDICE	Y	N	P
LIVER DISEASE	Y	N	P	ULCERS	Y	N	P
VOMITTING BLOOD	Y	N	P	VOMITTING	Y	N	P

BOWEL MOVEMENTS:

HOW OFTEN? ____ IS THIS A CHANGE? Y N

CONSTIPATION? Y N P DIARRHEA? Y N P

URINARY

FREQUENT INFECTIONS	Y	N	P	FREQUENCY AT NIGHT	Y	N	P
INCREASED FREQUENCY	Y	N	P	INABILITY TO HOLD	Y	N	P
KIDNEY STONES	Y	N	P	KIDNEY PAIN	Y	N	P
PAIN ON URINATION	Y	N	P	URETHRAL DISCHARGE	Y	N	P

FEMALE REPRODUCTIVE SYSTEM

AGE MENSES BEGAN _______________				BIRTH CONTROL	Y	N	P
# OF DAYS YOU BLEED _____________				WHAT TYPE _________________________________			
# OF DAYS BETWEEN PERIODS ______				# OF PREGNANCIES ___________________________			
ARE CYCLES REGULAR	Y	N	P	# OF LIVE BIRTHS ______________________________			
PAIN WITH PERIODS	Y	N	P	# OF MISCARRIAGES ___________________________			
EXCESSIVE FLOW	Y	N	P	# OF ABORTIONS ______________________________			
PMS	Y	N	P	DIFFICULTY CONCEIVING	Y	N	P
VAGINAL DRYNESS	Y	N	P	MENOPAUSAL SYMPTOMS	Y	N	P
PAIN WITH INTERCOURSE	Y	N	P	VENEREAL DISEASE	Y	N	P
DECREASED SEX DRIVE	Y	N	P	ARE YOU SEXUALLY ACTIVE	Y	N	P
				SEXUAL PREFERENCE:			
				HETEROSEXUAL ☐ BISEXUAL ☐ HOMOSEXUAL ☐			

BREASTS

DO YOU DO SELF EXAMS	Y	N	P	LUMPS	Y	N	P
PAIN	Y	N	P	NIPPLE DISCHARGE	Y	N	P
MAMMOGRAMS	Y	N	P	BIOPSY	Y	N	P

MALE REPRODUCTIVE SYSTEM

HERNIAS	Y	N	P	ABNORMAL RECTAL EXAM	Y	N	P
TESTICULAR PAIN	Y	N	P	DO YOU DO SELF EXAMS?	Y	N	P
TESTICULAR MASSES	Y	N	P	ARE YOU SEXUALLY ACTIVE?	Y	N	P
DISCHARGE OR SORES	Y	N	P	DECREASED SEX DRIVE	Y	N	P
PROSTATE DISEASE/PAIN	Y	N	P	SEXUAL DIFFICULTIES	Y	N	P
VENEREAL DISEASE	Y	N	P	SEXUAL PREFERENCE:			
HIGH PSA	Y	N	P	HETEROSEXUAL ☐ BISEXUAL ☐ HOMOSEXUAL ☐			

MUSCULOSKELETAL

JOINT PAIN/STIFFFNESS	Y	N	P	BROKEN BONES	Y	N	P
SWELLING OF JOINTS	Y	N	P	MUSCLE CRAMPS	Y	N	P
ARTHRITIS	Y	N	P	WEAKNESS	Y	N	P
GOUT	Y	N	P	OSTEOPENIA	Y	N	P

PERIPHERAL VASCULAR

COLD HANDS/FEET	Y	N	P	VARICOSE VEINS	Y	N	P
DEEP LEG PAINS	Y	N	P	THROMBOPHLEBITIS	Y	N	P
NUMB HANDS/FEET	Y	N	P	RAYNAUD'S	Y	N	P

NEUROLOGICAL

DIZZINESS/VERTIGO	Y	N	P	NUMBNESS/TINGLING	Y	N	P
FAINTING	Y	N	P	LOSS OF MEMORY	Y	N	P
SEIZURES	Y	N	P	PARALYSIS	Y	N	P
WEAKNESS	Y	N	P	OTHER __________________________________			

ENDOCRINE/BLOOD

ANEMIA	Y	N	P	EXCESSIVE THIRST	Y	N	P
EASY BRUISING/BLEEDING	Y	N	P	HEAT/COLD INTOLERANCE	Y	N	P
EXCESSIVE HUNGER	Y	N	P	HYPOTHYROID	Y	N	P

CURRENT WEIGHT _____________ WEIGHT 1 YEAR AGO _____________ IDEAL WEIGHT _______________ HEIGHT _______________

MENTAL/EMOTIONAL

ANXIETY/NERVOUSNESS	Y	N	P	EXCESSIVE FEARS	Y	N	P
DEPRESSION	Y	N	P	MOOD SWINGS	Y	N	P
EXCESSIVE ANGER	Y	N	P	HYPERACTIVITY	Y	N	P
ATTENTION DEFICIT	Y	N	P	EXCESSIVE STRESS	Y	N	P

INFANTS AND SMALL CHILDREN

EAT WELL	Y	N	CONSTIPATION	Y	N	LETHARGY	Y	N
SLEEP THROUGH NIGHT	Y	N	COLIC	Y	N	HYPERACTIVE	Y	N
EAR ACHES	Y	N	DIARRHEA	Y	N	BEHAVIOR PROBLEMS	Y	N
WEIGHT LOSS/GAIN	Y	N	SKIN RASHES	Y	N	IRRITABILITY	Y	N
DEVELOPMENT ABNORMAL	Y	N	EXCESS FEARS	Y	N	OTHER____________________		

HABITS

OF HOURS YOU SLEEP ______________

DO YOU WAKE RESTED	Y	N	P
SMOKING	Y	N	P
ALCOHOL USE	Y	N	P
RECREATIONAL DRUGS	Y	N	P
TREATMENT FOR DRUG DEPENDENCE	Y	N	P
TREATMENT FOR ALCOHOL ABUSE	Y	N	P

YOUR MAIN HOBBIES AND INTERESTS

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EXERCISE HABITS AND FREQUENCY

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DO YOU HAVE A RELIGIOUS/SPIRITUAL PRACTICE?	Y	N	P
ARE YOU SEEING A COUNSELOR?	Y	N	P
DO YOU SEE A CHIROPRACTOR	Y	N	P
ARE YOU RECEIVING ACUPUNCTURE TREATMENTS	Y	N	P

WHAT ARE YOU DOING TO SUPPORT YOUR HEALING AND GROWTH? ______________________________________

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IS THERE ANYTHING ELSE YOU THINK I NEED TO KNOW TO HELP YOU WITH YOUR HEALING PROCESS?

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