

Flow Natural Medicine & Acupuncture
Nina Walsh, ND, LAc

Date: _____ Mr. Mrs. Ms. Ms. Marital Status: M S W D

Name: _____ Sex: F M

Address: _____ City: _____ State: _____ Zip: _____
First Middle Initial Last

Age: _____ Birth Date: _____ Phone(home) _____ Work/Cell: _____

SS #: _____ Occupation: _____ Employer: _____

In Case of Emergency (Name): _____ Phone: _____

What Other Healthcare Are You Currently Receiving: _____

_____ Date of Last Physical Exam: _____

Name of physician _____ Phone: _____

Note: Please complete the questionnaire as thoroughly as possible so we can have a complete picture of your health which is necessary in order to provide Naturopathic, holistic and preventative healthcare.

Present Health Concerns:

1. _____
2. _____
3. _____
4. _____

Your Health History: Your health as a child was? Good Fair Poor **Childhood Illnesses:** Mumps Pertussis
Measles Rheumatic Fever Chicken Pox Dyptheria German Measles Asthma Eczema

Surgeries (Year/Type): _____

Hospitalizations (Year/Reason) _____

Vaccinations (Year/Type/Adverse Reactions?) _____

Medications and Supplements: Please list all prescription and non-prescription drugs with dosage (pills, liquids, ointments, suppositories, etc)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergies: List any allergies and their adverse effects (food, drugs, inhalants, chemicals, etc)

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Review of Systems: Please circle **Y** for a condition you have now **P** - for a condition you had in the past **N** – never had

General:				Pain when breathing	Y	P	N	Difficulty falling asleep	Y	P	N
Weight				Shortness of breath:	Y	P	N	Difficulty staying asleep	Y	P	N
Weight 1 year ago				While lying down	Y	P	N	Waking not rested	Y	P	N
Max weight				At night	Y	P	N	Remember dreams	Y	P	N
When				On exertion	Y	P	N	Endocrine			
Height:				Positive TB test	Y	P	N	Thyroid problems	Y	P	N
Night Sweats	Y	P	N	Heart:				Heat/cold intolerance	Y	P	N
Fatigue	Y	P	N	Heart disease:	Y	P	N	Hypoglycemia	Y	P	N
				High Blood pressure	Y	P	N	Excessive hunger	Y	P	N
Skin:				Chest pain	Y	P	N	Easy weight gain	Y	P	N
Rashes	Y	P	N	Swelling in ankles	Y	P	N	Emotional:			
Inflammation	Y	P	N	Palpitations/fluttering	Y	P	N	Depression	Y	P	N
Infection	Y	P	N	Digestion:				Mood swings	Y	P	N
Growths	Y	P	N	Trouble swallowing	Y	P	N	Anxiety/nervousness	Y	P	N
Change in hair/nails	Y	P	N	Heartburn	Y	P	N	Tension	Y	P	N
Head:				Stomach pain	Y	P	N				
Headaches	Y	P	N	Thirst	Y	P	N				
Head injury	Y	P	N	Change in appetite	Y	P	N	Male Reproduction:			
Ears:				Nausea	Y	P	N	Hernia	Y	P	N
Impaired hearing	Y	P	N	Vomiting	Y	P	N	Testicular pain	Y	P	N
ringing	Y	P	N	Loose stools	Y	P	N	Testicular masses	Y	P	N
Ache or itch	Y	P	N	Blood stools	Y	P	N	Sexually active	Y	P	N
Dizziness	Y	P	N	Belching/gas	Y	P	N	Sexual difficulties	Y	P	N
Eyes:				Liver disease	Y	P	N	Prostate problems	Y	P	N
Impaired vision	Y	P	N	Gall bladder disease	Y	P	N	STDs	Y	P	N
Eye pain	Y	P	N	Hemorrhoids	Y	P	N	Discharge/sores	Y	P	N
Tearing/dryness	Y	P	N	Constipation	Y	P	N	Last DRE			
Double vision	Y	P	N	Bowels move: daily more less				Last colonoscopy			
Nose and sinus:				Urinary:				Last PSA testing			
Frequent colds	Y	P	N	Pain on urination	Y	P	N				
Nose bleeds	Y	P	N	Increased frequency	Y	P	N				
Congestion	Y	P	N	Urgency	Y	P	N				
Post nasal drip	Y	P	N	Urination at night	Y	P	N				
Mouth and Throat:				Inability to hold urine	Y	P	N				
Frequent sore throat	Y	P	N	Dribbling	Y	P	N	Musculoskeletal:			
Sore tongue	Y	P	N	Bladder infections	Y	P	N	Joint pain/stiffness	Y	P	N
Sores on mouth/lips	Y	P	N	Circulation:				Broken bones	Y	P	N
Gum problems:				Deep leg pain	Y	P	N	Muscle spasms/cramps	Y	P	N
Dental problems	Y	P	N	Cold hands/feet	Y	P	N	Muscle weakness	Y	P	N
Neck:				Varicose veins	Y	P	N				
Swollen glands	Y	P	N	Neurological:	Y	P	N				
Pain or stiffness	Y	P	N	Fainting	Y	P	N				
Blood:				Seizures	Y	P	N				
Anemia	Y	P	N	Paralysis	Y	P	N				
Easy bleeding/bruising	Y	P	N	Muscle weakness	Y	P	N				
Respiratory:				Numbness/tingling	Y	P	N				
Cough	Y	P	N	Memory problems	Y	P	N				
Spitting up blood	Y	P	N	Concentration problems	Y	P	N				
Wheezing	Y	P	N	Sleep:							
Difficulty breathing	Y	P	N	Total hours of sleep/night							

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Female Gynecological History: Menstrual history: Date of last period? _____

Age menstruation began? _____ Length of cycle? _____ Number of days in flow? _____

Regular cycle? Yes No Flow heavy or light? Abnormal discharge? Y N Cramping? Y N

Blood clots? Y N

Do you experience symptoms of PMS? Y N If yes, please describe: _____

Do you have a history of the following vaginal infections?

Yeast infection Y N Gonorrhea Y N Herpes Y N Chlamydia Y N Vaginitis Y N

HPV Y N Syphilis Y N

Do you have a history of the following?

Ovarian cysts Y N Uterine Fibroids Y N Endometriosis Y N

Date of last PAP _____ Were the results normal? Y N

Have you ever had an abnormal PAP? Y N If so, when? _____

Please list the number associated with the following:

Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Type of birth control currently used: _____ Past OCP use: type, dates _____

Any pain during intercourse? Y N Difficulty conceiving? Y N

If yes, please describe: _____

Breast health:

Lumps present? Y N Pain/tenderness? Y N Nipple Discharge? Y N

Do you do a breast self-exam regularly? Y N If answered yes to any of the above please describe: _____

Date of last mammogram? _____ Findings? _____

Anything else your naturopathic doctor should be aware of? _____

Menopausal symptoms? Y N Please describe:

Habits: Alcohol? Y N **What kind and how many per week?** _____

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Coffee: Y N Caffeinated Decaf **Cups per day?** _____ **Recreational drugs:** Y N
Tobacco: Y N **Amount per day/week?** _____ **How long?** _____
Your diet: Any diet restrictions or regimen? _____

Are you satisfied with your diet as it is now? Y N **Do you eat three meals daily?** Y N

Do crave Starches? Y N **Sweets:** Y N **Salt:** Y N **Fats:** Y N

Please write down two samples of each meal that you eat often. Include desserts and snacks

Breakfast: 1. _____ 2. _____
Morning Snack: 1. _____ 2. _____
Lunch: 1. _____ 2. _____
Afternoon Snack: 1. _____ 2. _____
Dinner: 1. _____ 2. _____
Late Snack/Dessert 1. _____ 2. _____

What kind water do you drink: Tap Filtered Distilled Well **How many glasses per day?** _____

Do you drink soft drinks? Y N **How many per day/week?** _____ **Other beverages:** _____
 _____ **Do you salt your food?** Y N **If so, how much?** Light Moderate heavy

Do you use sugar? Y N **How much?** **Do you use artificial sweeteners?** Y N **What kind?** _____

Describe your appetite in the: Morning _____ Noon _____ Evening _____

Exercise: Do you exercise regularly? Y N **How often?** _____ **How long?** _____
 What type? _____

Family History	Father	Mother	Brothers	Sisters	Partner	Children
Age (if living)						
Health G-good, P-poor						
Age (at death)						
Cause of death						

Please identify known conditions within your family and list the family member's relationship to yourself:

Diabetes: Y N _____ **Mental Illness:** Y N _____
Heart disease: Y N _____ **Kidney Disease:** Y N _____
Stroke: Y N _____ **Asthma:** Y N _____
Hypertension: Y N _____ **Allergies:** Y N _____
Alcoholism: Y N _____ **Hives:** Y N _____
Cancer: Y N _____ **Tuberculosis:** Y N _____
Glaucoma: Y N _____ **Physical abuse:** Y N _____