HARMONY
FAMILY MEDICINE

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Doctor of Naturopathic Medicine

Adult Patient Health History

Today's Date: _____

Patient's Name: _____
(Last) (First) (Middle)

Age: _____ Birthdate: _____ Gender assigned at birth: M F Gender identity: M F

Occupation: _____

Address: _____
(Street, City, State, Zip)

Mailing Address (if different): _____
(Street, City, State, Zip)

E-mail address: _____

Phone(s): _____
(Home) (Work) (Other)

What is your current living and relationship situation? _____

_____

Emergency contact: _____
(Name) (Phone)

Relationship: _____

How did you learn about my practice? _____

What are your most important health concerns in order of importance?

1. _____
2. _____
3. _____

When and where did you last receive healthcare? _____

What was the reason? _____

Please list traumatic events in your life that you believe have impacted your health: _____

_____

CHILDHOOD ILLNESSES (Y=yes, N=never, ?=not sure)

Measles (14-day Rubeola) ____	Frequent colds ____	Pneumonia ____
Mumps ____	Strep throat ____	Tonsillitis ____
Rubella (3-day German measles) ____	Scarlet Fever ____	Ear Infections ____
Chickenpox ____	Rheumatic Fever ____	Diabetes ____

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Skin rashes ____ Herpes ____

Chronic diarrhea or constipation _____

Other (please list) _____

IMMUNIZATIONS

MMR (measles, mumps, rubella) ____ Chickenpox ____ Influenza (flu) ____

DPT (diptheria, pertussis, tetanus) ____ Tetanus ____ Hepatitis ____

Polio ____

Others (please list) _____

HOSPITALIZATIONS & SURGERIES (list reason &/or type of surgery and date): _____

_____

_____

SCREENINGS/EVALUATIONS (list the date of your last screening):

Blood work (type): _____ Bone densitometry: _____

Pap smear & result: _____ Physical: _____

Mammogram: _____ EKG: _____

Testicular exam: _____ X-ray: _____

Prostate exam: _____

ALLERGIES Please list known allergies to medication, food, or environment: _____

_____

_____

ENVIRONMENTAL EXPOSURE Are you aware or do you suspect that you have been exposed to toxic substances in your home or work environment? Please describe: _____

_____

_____

MEDICATIONS

	Now	Past		Now	Past
Antibiotics	____	____	Hormones	____	____
Decongestants	____	____	Antidepressants	____	____
Anti-histamine	____	____	Sleeping pills	____	____
Inhalers	____	____	Tranquilizers	____	____
Insulin	____	____	Pain relievers	____	____
Diet pills	____	____	Cortizone	____	____
Antacids	____	____	Laxatives	____	____
Thyroid medication	____	____			

Others: _____

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List all current medications, dosage, and reason for taking (or attach a list)

_____

_____

List all current vitamins/supplements/herbs/homeopathics, dosage, and reason for taking (or attach a list)

_____

_____

FAMILY HISTORY

Check those applicable	Father	Mother	Sibling	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____
Health: G=good P=poor	_____	_____	_____	_____	_____
Cancer (type?)	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____
Asthma, hay fever, hives	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____
Gallbladder disease	_____	_____	_____	_____	_____
Liver disease	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____
Ulcer	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Rheumatoid arthritis	_____	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____	_____
Age deceased	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____

Other _____

PRENATAL/BIRTH/NEONATAL HISTORY (if known)

Mother's health during pregnancy

Hypertension ____ Smoking, alcohol, drug use _____
Diabetes ____ Physical or emotional trauma _____
Thyroid problems ____ Illnesses _____

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Medications _____

Mother's age at birth of child: _____

Term: Full ____ Premature ____ Late ____ Birth wt: _____lbs ____oz

List complications during labor or at birth: _____

_____

Neonatal complications (ie: colic, jaundice, heart murmur) _____

HABITS

What are your main interests and hobbies? _____

_____

Do you exercise? Y N What forms and how often? _____

_____

Diet

Do you eat three meals daily? Y N Blood Type? A B AB O

Please describe a typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How many glasses of water do you drink daily? _____

Do you drink caffeinated products? Y N If so, what kind? _____

Do you have any food intolerances that you know of? Y N If yes, please explain _____

_____

Sleep

Do you sleep well? Y N

Awaken rested? Y N

Average 6-8 hrs sleep per day? Y N

Work

Work unusual hours? Y N

Enjoy your work? Y N

Take vacations? Y N

Other

Spend time outdoors? Y N Hours/day? _____

Read? Y N

Spend time in front of the TV? Y N Hours/day? _____

Other screen time? Y N Hours/day? _____

Do you have a meditation practice? Y N

Ever use tobacco? Y N How much? _____ How long? _____

Drink alcohol? Y N How much? _____

Been treated for alcoholism? Y N

Use recreational drugs? Y N

Been treated for drug abuse? Y N

REVIEW OF SYSTEMS (Y=yes, P=past, N=never)

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General

Weight _____
Satisfied with wt? Y / N
Weight 1 yr ago _____
Maximum wt _____
When? _____
Height _____
Fatigue Y P N
Night sweats Y P N

Skin

Hives Y P N
Eczema Y P N
Chronic rash Y P N
Acne, boils Y P N
Itching Y P N
Color change Y P N
Lumps Y P N
Herpes Y P N
Loss of hair Y P N
Psoriasis Y P N

Head

Headaches Y P N
Head injury Y P N
Jaw/TMJ problems Y P N

Eyes

Change in vision Y P N
Double vision Y P N
Glaucoma Y P N
Cataracts Y P N
Floaters Y P N
Eye pain Y P N
Tearing or dryness Y P N
Glasses or contacts Y P N

Ears

Impaired hearing Y P N
Ringing Y P N
Dizziness Y P N
Earache Y P N

Nose/sinuses

Frequent colds Y P N
Stuffiness Y P N
Loss of smell Y P N
Sinus infections Y P N
Hay fever Y P N
Frequent nose bleeds Y P N

Mouth & throat

Frequent sore throat Y P N
Canker sores Y P N
Sore/swollen tongue Y P N
Sore lips Y P N
Bleeding/receding gums Y P N
Dental cavities Y P N
Toothache/sensitivities Y P N
Difficulty swallowing Y P N
Hoarseness Y P N
Frequently clear throat Y P N

Neck

Lumps Y P N
Swollen glands Y P N
Goiter Y P N
Pain or stiffness Y P N

Respiratory

Wheezing Y P N
Asthma Y P N
Emphysema Y P N
Difficulty breathing Y P N
Cough Y P N
Productive cough Y P N
Bronchitis Y P N
Shortness of breath Y P N
At night? Y P N
Lying down? Y P N
Pain on breathing Y P N
Pneumonia Y P N
Pluerisy Y P N
Tuberculosis Y P N

Cardiovascular

Fainting Y P N
Heart disease Y P N
Chest pain/angina Y P N
Low/high blood press. Y P N
High cholesterol Y P N
Fluttering in chest Y P N
Heart murmur Y P N
Rheumatic fever Y P N
Swelling in ankles Y P N

Gastrointestinal

Change in thirst Y P N
Change in appetite Y P N
Nausea Y P N
Frequent indigestion Y P N
Vomiting Y P N
Vomiting blood Y P N
Blood in stool Y P N
Black stool Y P N
Abdominal pain Y P N
Gallbladder pain Y P N
Liver disease/hepatitis Y P N
Jaundice Y P N
Frequent belching/gas Y P N

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Heartburn Y P N
Ulcers Y P N
Hemorrhoids Y P N
Constipation Y P N
Diarrhea Y P N
Bowel movements
How often? _____
Is this a change? Y / N

Urinary
Pain on urination Y P N
Increased frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Bloody urine Y P N
Frequent infections Y P N
Kidney stones Y P N

Breasts
Do you self-exam? Y P N
Lumps Y P N
Pain or tenderness Y P N
Nipple discharge Y P N

Female reproductive
Age of 1st menses _____
Regular cycles Y P N
Skipped cycles Y P N
Length of cycle _____
Duration of menses _____
Painful menses Y P N
Heavy flow Y P N
Bleeding b/w periods Y P N
PMS Y P N
Menopausal symptoms Y P N
Age of last menses (if menopausal) ____
Sexually active Y P N
Pain with intercourse Y P N
Birth control Y P N
What type? _____
# of pregnancies _____
# of live births _____
# of miscarriages _____
# of abortions _____
Difficulty conceiving Y P N
Ovarian cysts Y P N
Sexually transmitted disease
Y P N
Sexual difficulties Y P N
Frequent vaginal infect. Y P N
Sexual preference
Heterosexual Y P N
Bisexual Y P N
Homosexual Y P N
Date of last annual exam _____

Abnormal pap Y P N
Cervical dysplasia Y P N

Male reproductive
Hernias Y P N
Testicular lump Y P N
Testicular pain Y P N
Prostate disease Y P N
Sexually active Y P N
Birth control Y P N
What type? _____
Sexual difficulties Y P N
Difficulty conceiving Y P N
Sexually transmitted disease
Y P N
Discharges or sores Y P N
Sexual preference
Heterosexual Y P N
Bisexual Y P N
Homosexual Y P N

Musculoskeletal
Joint pain/stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Osteopenia Y P N
Osteoporosis Y P N
Muscle spasms/cramps Y P N

Peripheral vascular
Thrombophlebitis Y P N
Varicose veins Y P N
Cold hands/feet Y P N
Deep leg pain Y P N

Blood
Anemia Y P N
Easy bleeding/bruising Y P N

Neurological
Head injury Y P N
Stroke Y P N
Seizures Y P N
Fainting Y P N
Loss of coordination Y P N
Paralysis Y P N
Numbness or tingling Y P N
Memory loss Y P N
Loss of taste or smell Y P N
Loss of balance Y P N
Muscle weakness Y P N

Endocrine
Hyperthyroid Y P N
Hypothyroid Y P N

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Heat/cold intolerance	Y	P	N	Feel out of control	Y	P	N
Diabetes	Y	P	N	Feel stressed out	Y	P	N
Excessive thirst	Y	P	N	Feel nervous	Y	P	N
Excessive hunger	Y	P	N	Indecisive	Y	P	N
Excessive urination	Y	P	N	Feel isolated	Y	P	N
Excessive fatigue	Y	P	N	Uncontrolleld anger	Y	P	N
				Feel afraid	Y	P	N
Emotional				Loss of self-esteem	Y	P	N
Anxiety	Y	P	N	Feel victimized	Y	P	N
Depression/sadness	Y	P	N	Anorexia/bulimia	Y	P	N
Mood swings	Y	P	N				

Informed Consent

Naturopathic Doctors are registered by the state to practice naturopathic medicine under the "Naturopathic Doctor Act". They are not permitted to perform the following acts:

- Prescribe, dispense, administer or inject any prescription medications or devices other than B-12, B-6, epinipherine, topical anesthetics, and barrier contraceptives (not including IUDs).
- Perform surgical procedures, including surgical procedures using a laser device; however the removal of surface lesions and suturing of the skin is permissible.
- Use general or spinal anesthetics, other than topical anesthetics.
- Administer ionizing radioactive substances for therapeutic purposes.
- Treat a child, unless
    - An informed consent for treatment is completed and signed.
    - The most recent immunizations schedule recommended by the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the federal Department of Health and Human Services is provided to the parent or guardian with this form.
    - A release of information is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric healthcare provider, if the child has one.
- Practice medicine, surgery, or any other form of healing other than Naturopathic Medicine.
- Practice obstetrics.
- Perform chiropractic services (spinal adjustments, manipulation, or mobilization). Physical medicine as described in 12-37.3-102(12)(b), C.R.S., is permitted
- Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner.

Because there are services that a Naturopathic Doctor can not provide it is recommended that you also have a relationship with a licensed physician or a licensed pediatrician (if under the age of 8). If you need a referral, I would be happy to provide one. Naturopathic Doctors are one part of the Colorado Health Model and as such we often collaborate with other healthcare professionals. We will work to develop and maintain collaboration with your physician in order to provide you the best possible care.

As a patient of a Naturopathic Doctor your experience at the office may include an intake, appropriate exams and diagnostic tests, collaboration with your other healthcare providers and treatment that may involve but is not limited to any of the following modalities:

- Nutritional Supplementation
- Dietary and Nutritional Recommendations

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- Botanical Medicine
- Hydrotherapy
- Naturopathic Physical Medicine
- Minor Office procedures to include but not limited to sutures for lacerations and removal of cysts.
- Administration of approved vitamins and medications
- Counseling

Disclosure Statement

1. I, Meghan Van Vleet, ND, am a Naturopathic Doctor registered under Title 12, Article 37.3, of the Colorado Revised Statutes.
2. I am not a medical doctor or a physician licensed under Title 12, Article 36, of the Colorado Revised Statutes.
3. I recommend that the patient named below have a relationship with a licensed physician, or if the patient is a child aged two to seven, with a licensed pediatric healthcare provider.
4. If the patient is a child aged two to seven, I recommend that the child's parent or guardian follow the immunization schedule that accompanies this form.
5. If the patient has a relationship with a licensed physician or pediatric healthcare provider, I will attempt to develop and maintain a collaborative relationship with the physician or pediatric healthcare provider. To permit this, the patient (or patient's parent/guardian if patient is a minor) will need to sign a separate release allowing me to exchange the information with the licensed physician or pediatric healthcare provider.
6. **PWCB Disclaimer:** As a patient of Harmony Family Medicine PLLC at the Postpartum Wellness Center of Boulder, I understand that I am receiving treatment at a facility that works toward comprehensive and collaborative care whenever possible in an effort to provide best-practice treatment to its patients. I understand that my case may be discussed in collaborative care consultations with other clinicians at the PWCB. I understand that by signing this document, I give Meghan Van Vleet, ND, RND permission to address my case in these meetings when necessary.

_____ _____

Naturopathic Doctor Signature Date

By signing this informed consent I hereby acknowledge receipt of the above disclosure statement and give my informed consent to being a patient and receiving treatment.

_____

Patient Printed Name

_____ _____

Patient Signature Date

Thank You.

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