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GRAND RAPIDS NATURAL HEALTH INITIAL PAPERWORK

Patient Name_____Age____Date of Birth____/___/____Sex: F M

Address_____City_____State_____Zip_

_____

Daytime Phone_____Evening Phone_____Cell Phone_____

Occupation_____Employer_____

Email Address:_____

Emergency Contact:_____Phone:_____

Primary care provider: _____Contact info (Phone, email):_____

Referring provider:_____Contact info (Phone, email):_____

Specialist Provider (Ex. Cardiologist):_____Contact info (Phone, email):_____

How did you hear about us?_____

What is the reason for your visit today? _____

_____

Primary Health Concerns: (In order of importance)

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

When was the last time you felt well?

_____

Did something trigger your health change? _____

What makes you feel worse?

_____

What makes you feel better? _____

PATIENT: _____ **DATE OF BIRTH:** _____

PAST MEDICAL HISTORY

MEDICAL DISEASES/CONDITIONS/DIAGNOSIS *Check appropriate box and provide date of onset (P = past condition, O = ongoing condition)*

P	O	**GASROINTESTINAL**	P	O	**MUSCULOSKELETAL/PAIN**
		Irritable bowel syndrome			Osteoarthritis
		Inflammatory bowel disease			Fibromyalgia
		Crohn's			Chronic pain
		Ulcerative colitis			Other
		Gastritis or peptic ulcer disease			**INFLAMMATORY/AUTOIMMUNE**
		GERD (reflux)			Chronic fatigue syndrome
		Celiac disease			Autoimmune disease
		Other			Rheumatoid arthritis
		CARDIOVASCULAR			Lupus (SLE)
		Heart attack			Immune deficiency disease
		Other heart disease			Genital herpes
		Stroke			Lyme disease
		Elevated cholesterol			Severe infectious disease
		Arrhythmia (irregular heart rate)			Poor immune function (frequent infections)
		Hypertension (high blood pressure)			Food allergies
		Rheumatic fever			Environmental allergies
		Mitral valve prolapse			Multiple chemical sensitivities
		Other			Latex allergy
		METABOLIC/ENDOCRINE			Other
		Type 1 diabetes			**RESPIRATORY DISEASES**
		Type 2 diabetes			Asthma
		Hypoglycemia			Chronic sinusitis
		Metabolic syndrome (insulin resistance or pre-diabetes)			Bronchitis/Emphysema
		Hypothyroidism			Pneumonia
		Hyperthyroidism			Tuberculosis
		Endocrine problems			Sleep apnea
		Polycystic ovarian syndrome (POCS)			Other
		Infertility			**SKIN DISEASES**
		Weight gain			Eczema
		Weight loss			Psoriasis
		Frequent weight fluctuations			Acne
		Bulimia			Melanoma
		Anorexia			Skin cancer
		Binge eating disorder			other
		Night eating syndrome			**NEUROLOGICAL/PSYCHOLOGICAL**
		Eating disorder (non-specific)			Depression
		Other			Anxiety
		CANCER			Bipolar disorder
		Lung cancer			Schizophrenia
		Breast cancer			Headaches
		Colon cancer			Migraines
		Ovarian cancer			ADD/ADHD
		Prostate cancer			Autism
		Skin cancer			Mild cognitive impairment
		Other			Memory problems
		GENITAL AND URINARY SYSTEM			Parkinson's disease
		Kidney stones			Multiple sclerosis
		Gout			ALS
		Interstitial cystitis			Seizures
		Frequent urinary tract infections (UTI)			Other psychological disorder
		Frequent yeast infections			Other neurological disorder
		Erectile dysfunction or sexual dysfunction			
		Other			

PATIENT: _____ DATE OF BIRTH: _____

PAST SURGERIES *Check box if yes and provide date of surgery*

	SURGERY	**DATE**
	Appendectomy	
	Hysterectomy + / - ovaries	
	Gall bladder	
	Hernia	
	Tonsillectomy	
	Dental surgery	
	Joint replacement – knee / hip	
	Heart surgery – bypass / valve	
	Angioplasty or stent	
	Pacemaker or defibrillator	
	Breast implants	
	Other	
	None	

PAST HOSPITALIZATIONS

Reason for hospitalization	Date of hospitalization

ALLERGIES

Medications/Food/Environmental allergy	*Reaction/Intolerance*

PATIENT: _____ **DATE OF BIRTH:** _____

CURRENT MEDICATIONS: Please List the Medications you are currently taking: (with dosage)

Medication	Reason	Year started	Dosage

CURRENT SUPPLEMENTS: Please list the supplements, vitamins, or herbs you are taking: (with dosage)

Product name	Reason	Year started	Dosage

GYNECOLOGIC HISTORY (for women only)

OBSETRIC HISTORY *Check box if yes and provide number of*

	Pregnancies		Caesarian		Vaginal deliveries
	Miscarriage		Abortion		Living children

Have you suffered from:

☐ Post-partum depression ☐ Toxemia ☐ Gestational diabetes ☐ Baby over 8 pounds

Did you breast feed and for how long? _____

MENSTRUAL HISTORY

Age at first period: _____ Last Menstrual period: _____

Menses frequency: _____ Length: _____ Pain: ☐ Yes ☐ No Clotting: ☐ Yes ☐ No

Has your period ever skipped? ☐ Yes ☐ No If so, for how long? _____

Use of hormonal contraception: ☐ Birth control pills ☐ Patch ☐ Nuva ring, how long? - _____

Do you use contraception? ☐ Yes ☐ No Type: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

PATIENT: _____ DATE OF BIRTH: _____

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility
☐ Painful periods ☐ Heavy periods ☐ PMS
Last mammogram: _____ ☐ Breast biopsy/date _____
Last PAP test: _____ ☐ Normal ☐ Abnormal
Last bone density: _____ Results: ☐ High ☐ Low ☐ Within Normal Limits
Are you in menopause: ☐ Yes ☐ No If so, age of menopause: _____
☐ Hot flashes ☐ Mood swings ☐ Concentration/memory problems ☐ Vaginal dryness
☐ Decreased libido ☐ Heavy bleeding ☐ Joint pains ☐ Headaches ☐ Weight gain
☐ Loss of control of urine ☐ Palpitations
Use of hormone replacement therapy: ☐ Yes ☐ No If so, for how long? _____

MEN'S HISTORY (for men only)

Have you ever has a PSA done: ☐ Yes ☐ No If so, date of last test: _____
PSA level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10
☐ Prostate enlargement (BPH) ☐ Prostate infection ☐ Change in libido (sex drive) ☐ Impotence
☐ Difficulty obtaining an erection ☐ Difficulty maintaining an erection
☐ Nocturia (urination at night). How many times at night? _____
☐ Urgency/hesitancy/change in urinary stream ☐ Loss of control of urine

PATIENT BIRTH HISTORY

☐ Term ☐ Premature
Pregnancy complications:
_____
Birth complications:
_____
Delivery: ☐ Vaginal ☐ Caesarian
☐ Breast fed How long? _____ ☐ Bottle Fed
Age at introduction of: Solid foods: _____ Dairy: _____ Wheat: _____
Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No

DENTAL HISTORY

☐ Silver mercury fillings How many? _____
☐ Gold fillings ☐ Root canals ☐ Implants ☐ Tooth pain ☐ Bleeding gums
☐ Problems with chewing ☐ Gingivitis ☐ Periodontal disease
Do you floss regularly? ☐ Yes ☐ No
Do you see a dentist annually? ☐ Yes ☐ No

PRIMARY CARE SCREENING EXAMS (when was your last one)

Last Eye exam: _____ Last DEXA: _____
Last Dental exam: _____ Last Blood work: _____
Last Pap and Mammogram: _____

PATIENT: _____ **DATE OF BIRTH:** _____

FAMILY HISTORY

	Mother	Father	Sister(s)	Brother(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon cancer												
Breast cancer												
Ovarian cancer												
Heart disease												
Obesity												
Diabetes												
Stroke												
Inflammatory arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)												
Inflammatory bowel disease												
Multiple sclerosis												
Auto-immune disease (such as lupus)												
Irritable bowel syndrome												
Celiac disease												
Asthma												
Eczema / psoriasis												
Food allergies, sensitivities or intolerances												
Environmental sensitivities												
Dementia												
Parkinson's												
ALS or other motor neuron disease												
Genetic disorders												
Substance abuse (such as alcoholism)												
Psychiatric disorders												
Depression												
Schizophrenia												
ADD/ADHD												
Autism												
Bipolar disease												

Provide any additional family history: _____

_____

_____

PATIENT: _____ **DATE OF BIRTH:** _____

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutritional consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Do you current follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low fat ☐ Low carbohydrate ☐ High protein ☐ Low sodium ☐ Diabetic ☐ No dairy

☐ No wheat ☐ Gluten-free ☐ Oil-free ☐ Vegetarian ☐ Vegan ☐ Ketogenic

☐ Other:_____

☐ Specific program for weight loss/maintenance Type:_____

Weight History:

Height (feet/inches):	Current weight:
Usual weight range:	Desired weight:
Highest adult weight:	Lowest adult weight
Weight fluctuations (>10 pounds) ☐ yes ☐ no	Body fat %:

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No

If yes, what was it? _____

Do you avoid any particular foods? ☐ Yes ☐ No If yes, types and reason:_____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? ☐ Yes ☐ No

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No

How many meals do you eat outside the home per week? ☐0-1 ☐1-3 ☐3-5 ☐>5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat > 50% meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Significant other or family members don't Like healthy foods
☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship with food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, stressed, bored, depressed)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

The most important thing I should change about my diet in order to improve my health is: _____

_____

_____

PATIENT: _____ DATE OF BIRTH: _____

SMOKING/ALCOHOL/OTHER SUBSTANCE USE

	No	Yes	Amount
Tobacco			
Caffeine			
Alcohol			
Drugs			

Prior DUI, or other alcohol/drug related incarceration _____

Previous heavy user _____ Year started _____, ended_____

EXERCISE

Current Exercise Program:

Activity	Type	Frequency per week	Duration in minutes
Stretching			
Cardio/aerobics			
Strength			
Other (yoga, pilates, etc)			
Sports or leisure activities (golf, tennis, rollerblading, etc)			

Rate your level of motivation for including exercise in your life: ☐ Low ☐ Medium ☐ High

List problems that limit physical activity: _____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: _____

Do you usually sweat when exercising? ☐ Yes ☐ No

SLEEP/REST

Average number of hours your sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No Explain: _____

Does your significant other sleep in a different room? ☐ Yes ☐ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No Are you content? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you belief stress is presently reducing your quality of life? ☐ Yes ☐ No

Do you like the work that you do? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

PATIENT: _____ DATE OF BIRTH: _____

STRESS/COPING

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

Do you feel that you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel that you can handle the stress in your life? ☐ Yes ☐ No

Daily Stressors: Rate of a Scale of 0 – 10 (0 = no stress, 10 = maximum stress)

Work_____ Family_____ Social_____ Finances_____ Health_____ Other _____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No How often: _____

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi
☐ Prayer ☐ Other_____

Have you ever been abused, a victim of a crime, or experienced significant trauma? ☐ Yes ☐ No

ROLES/RELATIONSHIP

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long term partnership ☐ Widow

List Children

Children's Full Name	Age	Gender	Living at home

Who is living in the household? Number: _____ Name(s): _____

Resources for emotional support:

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/spiritual ☐ Pets
☐ Other: _____

Life satisfaction

How well have things been going for you?	Very well	Fine	Poorly	N/A
- Overall				
- At school				
- In your job				
- In your social life				
- With close friends				
- With sex				
- With your attitude				
- With your boyfriend/girlfriend				
- With your children				
- With your parents				
- With your spouse				

PATIENT: _____ **DATE OF BIRTH:** _____

FOOD/ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have any known adverse food reactions or sensitivities? ☐ Yes ☐ No
Do you have any food allergies or sensitivities (*check all that apply*)

☐ Milk ☐ Eggs ☐ Peanuts ☐ Tree nuts (walnuts, almonds, pine nuts, etc)
☐ Soy ☐ Wheat or other grains with gluten ☐ Fish ☐ Shellfish
☐ Other: _____

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No
When you drink caffeine do you feel: Irritable or wired aches and pains
Do you react adversely to (*check all that apply*): ☐ Yes ☐ No

☐ Monosodium glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Caffeine ☐ Bananas
☐ Garlic ☐ Onion ☐ Cheese ☐ Citrus ☐ Chocolate ☐ Alcohol ☐ Red wine
☐ Sulfite containing foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. Sodium benzoate)
☐ Other:_____

Which of these significantly effect you: (*check all that apply*)
☐ Cigarette smoke ☐ Perfumes/colognes ☐ Auto exhaust fumes ☐ Other: _____
In you work or home environment, are you exposed to： (*check all that apply*)
☐ Chemicals ☐ Electromagnetic radiation ☐ Mold
Have you ever turned yellow (jaundiced)?
Have you ever been told you have Gilbert's Syndrome or a liver disorder?
Have you had any significant exposure to any harmful chemicals: (*check all that apply*)
☐ Herbicides ☐ Insecticides ☐ Pesticides ☐ Organic solvents ☐ Heavy metals
☐ Other:_____
Chemical name, date of exposure, length of exposure: _____
_____
Do you dry clean your clothes frequently? ☐ Yes ☐ No
Do you or have you lived in a damp or moldy environment or had other mold exposures? ☐ Yes ☐ No
Do you have pets or farm animals? ☐ Yes ☐ No

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing)
In order to improve your health, how willing are you to:

Significantly modify your diet……	☐5	☐4	☐3	☐2	☐1
Take several nutrition supplements every day……..	☐5	☐4	☐3	☐2	☐1
Keep a record of everything you eat each day……..	☐5	☐4	☐3	☐2	☐1
Modify your lifestyle (ex. Work demands, sleep habits)…	☐5	☐4	☐3	☐2	☐1
Practice a relaxation technique……	☐5	☐4	☐3	☐2	☐1
Engage in regular exercise……	☐5	☐4	☐3	☐2	☐1
Have periodic lab tests to assess your progress……	☐5	☐4	☐3	☐2	☐1

Comments: _____
_____

Rate on a scale of 5 (very confident) to 1 (not confident at all)
How confident are you of your ability to organize and follow through on the above health related activities?
☐5 ☐4 ☐3 ☐2 ☐1
If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____
_____
_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive)
At the present time, how supportive do you think people in your household will be to your implementing the above changes?
☐5 ☐4 ☐3 ☐2 ☐1

PATIENT: _____ DATE OF BIRTH: _____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact)
How much on-going support and contact (ex. Telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?

☐5 ☐4 ☐3 ☐2 ☐1

Comments: _____
_____
_____

ADDITIONAL INFORMATION/QUESTIONS/CONCERNS

Please provide any additional information:

PATIENT: _____ **DATE OF BIRTH:** _____

SYMPTOM REVIEW

Please mark those that apply to your present symptoms.

HEENT
- ☐ headaches
- ☐ dizziness
- ☐ blurry vision
- ☐ fainting/blackouts
- ☐ loss of balance
- ☐ eye pain/red eye
- ☐ cataracts/glaucoma
- ☐ earaches
- ☐ ringing in ears
- ☐ difficulty hearing
- ☐ nosebleeds
- ☐ loss of smell
- ☐ hoarse voice
- ☐ grinding teeth
- ☐ neck lumps/swelling
- ☐ dental problems
- ☐ sore throat
- ☐ sore/bleeding gums
- ☐ difficulty swallowing
- ☐ cold or canker sores

Chest
- ☐ wheezing
- ☐ cough up blood
- ☐ heart palpitations
- ☐ high blood pressure
- ☐ swollen ankles
- ☐ chest pain
- ☐ shortness of breath
- ☐ chest colds
- ☐ chest pain

Gastrointestinal
- ☐ stomach pain
- ☐ constipation
- ☐ diarrhea
- ☐ excessive appetite
- ☐ blood in stool
- ☐ indigestion
- ☐ nausea
- ☐ blood in vomit
- ☐ light colored stool
- ☐ vomiting
- ☐ gas/bloating
- ☐ clay colored stool
- ☐ rectal pain/itching
- ☐ yellow skin/jaundice
- ☐ loss of appetite
- ☐ blood in urine
- ☐ bladder infections

Genitourinary
- ☐ frequent urination
- ☐ urge to urinate
- ☐ incontinence
- ☐ difficulty urinating
- ☐ kidney stones
- ☐ sexual difficulty
- ☐ pain with urination
- ☐ genital sores
- ☐ STDs
- ☐ genital discharge

Musculoskeletal
- ☐ aching muscles
- ☐ numbness/tingling
- ☐ broken bones
- ☐ weakness
- ☐ sore joints
- ☐ leg cramps
- ☐ restless legs
- ☐ swollen joints
- ☐ tender point

Skin
- ☐ acne
- ☐ rashes
- ☐ easy bruising
- ☐ itching
- ☐ Lesions

Endocrine
- ☐ hives
- ☐ always cold
- ☐ always hot
- ☐ chronic fatigue
- ☐ weakness
- ☐ increased hunger
- ☐ increased thirst

Nervous
- ☐ anxiety
- ☐ loss of sensation
- ☐ tremor
- ☐ foggy thinking
- ☐ lack of strength
- ☐ convulsions
- ☐ loss of memory
- ☐ lack of concentration
- ☐ paralysis

Blood, Immune
- ☐ painful lymph nodes
- ☐ anemia
- ☐ swollen glands
- ☐ frequent bleeding
- ☐ fluid retention
- ☐ wounds heal slowly

Male Reproductive
- ☐ prostrate problems
- ☐ discharge
- ☐ painful testicles
- ☐ painful erections
- ☐ painful urination
- ☐ infertility
- ☐ difficult/premature ejaculation
- ☐ swelling in testicles
- ☐ trouble maintaining erection

Female Reproductive
- ☐ lumps in breast(s)
- ☐ breast pain
- ☐ missed periods
- ☐ lack of sexual desire
- ☐ pelvic pain
- ☐ vaginal discharge
- ☐ heavy periods
- ☐ genital eruptions
- ☐ pain with intercourse
- ☐ vaginal itching/burning
- ☐ spotting between periods
- ☐ difficulty having orgasms

Mental/emotional
- ☐ depressed mood
- ☐ suicidal thoughts
- ☐ angered easily
- ☐ restlessness
- ☐ mood swings
- ☐ excessive worry
- ☐ afraid of being alone
- ☐ shy/timidity
- ☐ mental confusion
- ☐ loneliness
- ☐ critical of others
- ☐ frequent crying
- ☐ suspicious/jealous
- ☐ confident/secure
- ☐ scary dreams

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete the Diet Diary or 3 consecutive days including one weekend day.

- Describe the food or beverage as accurately as possible: ex. Milk – what kind? (whole, 2%, nonfat),; toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated,with sugar and ½ and ½)
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items> For example: tea with 1 teaspoon honey, potato with 2 tablespoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas, etc.
- Include any additional comments about your eating habits on this form (ex. Craving sweet, skipped mea and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc)

Diet Diary – Day 1

Name: _____ **Date:** _____

Daily exercise (Type of activity / time of day / duration): _____

_____

Daily Bowel movements: _____

Sleep duration form night before: _____

Time	Food/Beverage amount	Comments

Diet Diary – Day 2

Name: _____ **Date:** _____

Daily exercise (Type of activity / time of day / duration): _____

_____

Daily Bowel movements: _____

Sleep duration form night before: _____

Time	Food/Beverage amount	Comments

Diet Diary – Day 3

Name: _____ **Date:** _____

Daily exercise (Type of activity / time of day / duration): _____

_____

Daily Bowel movements: _____

Sleep duration form night before: _____

Time	Food/Beverage amount	Comments