vitalhealth

Confidential Health Profile

All information is confidential. Please fill out as thoroughly as possible. Holistic health care is most effective when the doctor has an in-depth understanding of your health history & goals on multiple levels. **Please set aside at least 30 minutes to fill out this form.** Your honesty and thoughtfulness will greatly assist me in helping you. Please put a question mark next to any questions you are unsure about. Thank you very much for your time!

Name _____ Date of Birth _____ Today's Date _____

General Information

What are your primary health concerns/reasons for visit?	If applicable, please list prior approaches related to your concerns:		
	Prior diagnoses	Prior labs/imaging	Prior treatments

What expectations do you have of your **first visit** experience?

What **long-term** expectations do you have from working with me?

To what extent are you open to changes in lifestyle habits to address your concerns? *Please circle.* (least open) **1 2 3 4 5** (most open)

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? *Please list.*

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive? *Please list.*

Were there any life events in the 6 mos-1yr prior to you feeling unwell or to your onset of symptoms? Mention anything, even if it seems insignificant (e.g. changing jobs, moving, death in family, etc.)

Do you have any idea of what triggered or is causing your current symptoms?

Are you familiar with a naturopathic approach or have you ever seen an ND, chiropractor, acupuncturist, or other alternative provider?

If there are specific wellness therapies/programs you interested in, please check them here:
◊Nutritional counseling ◊Herbal Medicine ◊Homeopathy ◊Exercise therapy ◊Detoxification Program ◊4 Seasons Program
◊Disease prevention ◊Preconception Care ◊Emotional wellness ◊Weight loss program ◊Other

What are your supplement type preferences? *(√ all that apply and cross out those you are definitely not interested in))*
◊No preference ◊Powder ◊Liquid ◊Capsule/Tablet ◊Tea ◊Tincture (alcohol based) ◊I have difficulty taking supplements

Health Profile page two

CURRENT PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS, & SUPPLEMENTS (additional room on pg.5 if needed)					
Name (Include brand for supplements)	Dose&Frequency (ex. 500mg 3x/day)	Start date (approximate)	Reason for taking	Has it helped?	Who prescribed? (self or Dr. name)

Don't forget to include topical treatments, herbs, homeopathics & commonly used things like aspirin, antacids, pain-relievers, multivitamins.

Have you used any of the following for an extended period? *Circle.* Antibiotics Cortisone/Steroids Hormones

List all **allergies/sensitivities** & reaction (even if minor reaction) For ex: peanuts→trouble breathing *or* dairy→stuffy nose

*Drug/Supplement*_____ *Environment(pollens, etc)*_____

*Food*_____

Did you have vaccinations as a child? ◊Yes ◊No As an adult? ◊Yes ◊No Any adverse reactions? ◊Yes ◊No ◊Maybe/?

List and date all surgeries, hospitalizations, major injuries/illnesses *(don't forget tonsil/gallbladder/appendix removal &hysterectomy):*

Please list major childhood illnesses with approximate age *(don't forget chronic/frequent infections i.e. strep throat, earaches, mono):*

Check EXAMS, LABS, IMAGING which you have received, indicate date of most recent, and check if normal results or not:

Check if you have received	√	Date	Normal Results?	*Check if you have received*	√	Date	Normal Results?
Physical Exam	◊		◊Yes ◊No	EKG/ECG (heart study)	◊		◊Yes ◊No
Cholesterol check	◊		◊Yes ◊No	Mammogram ♀	◊		◊Yes ◊No
Blood sugar check	◊		◊Yes ◊No	Pap Smear ♀	◊		◊Yes ◊No
Colonoscopy/sigmoidoscopy	◊		◊Yes ◊No	Prostate Check ♂ (DRE, PSA)	◊		◊Yes ◊No
Fecal Occult Blood (√s for blood in stool)	◊		◊Yes ◊No	CT Scan/MRI *for*: _____	◊		◊Yes ◊No
Bone Density Scan(DEXA)	◊		◊Yes ◊No	X-ray *for:*_____	◊		◊Yes ◊No
STD/HIV Screen	◊		◊Yes ◊No	Ultrasound for:_____	◊		◊Yes ◊No

Family History

Condition	Self	Father	Mother	Sibling1	Sibling2	Grandmother (maternal)	Grandfather (maternal)	Grandmother (paternal)	Grandfather (paternal)
Age if living	N/A								
Age at death	N/A								
Cause of death	N/A								
√ box if applicable.									
Alcohol/Drug Addiction									
Alzheimer's									
Asthma/Allergies									
Autoimmune Disease									
Cancer (specify type)									
Celiac Disease									
Colitis/Crohn's									
Depression									
Diabetes									
Heart disease									
High blood pressure									
High cholesterol									
Mental illness(specify)									
Stroke									
Thyroid problems									
Other (specify)									

Health Profile page three

Review of Systems

Please circle as follows: (Y)=Yes, I currently have this problem (P)=I have had this in the past*

**For past problems, only circle if significant. Ex: everyone has had a cough due to a cold, so you don't need to circle this unless it was a recurrent/significant problem.*

Current weight: Maximum weight: Height: Are you content with your weight?

General ♦

Fatigue	Y	P
Night Sweats	Y	P
Sweats/perspire easily	Y	P
Fever/Chills	Y	P
Headaches	Y	P
Loss of/change in appetite	Y	P
Sensitive:		
-to smells/chemicals	Y	P
-to light/noise	Y	P
-to alcohol/meds	Y	P
Unintentional weight loss/gain	Y	P
Chronic fatigue syndrome	Y	P
Fibromyalgia	Y	P

Skin, Hair, Nails ♦

Dry skin	Y	P
Rashes/itching	Y	P
Acne, boils	Y	P
Slow wound healing	Y	P
Hives	Y	P
Warts	Y	P
Hair loss	Y	P
Dry, brittle hair/nails	Y	P
Dandruff/flaky scalp	Y	P
White spots on nails	Y	P
Deep ridges on nails	Y	P
Psoriasis	Y	P
Eczema	Y	P

Ears/Eyes ♦

Corrective lenses	Y	P
Impaired/double vision	Y	P
Dry eyes/tearing	Y	P
Eye pain	Y	P
Poor night vision	Y	P
Dark circles under eyes	Y	P
Earaches/infections	Y	P
Ringing in ears	Y	P
Hearing loss	Y	P
Excessive ear wax	Y	P

Nose and Sinuses ♦

Sinus problems	Y	P
Post nasal drip	Y	P
Stuffiness	Y	P
Nose bleeds	Y	P

Mouth and Throat ♦

Frequent sore throat	Y	P
Sore tongue	Y	P
Coated, white tongue	Y	P
Canker sores	Y	P
Cold sores	Y	P
Gum problems	Y	P
Bitter/strange taste	Y	P
Dental cavities	Y	
# of amalgam fillings: _____		
Root canals	Y	

Respiratory ♦

Cough	Y	P
Sputum	Y	P
Spitting up blood	Y	P
Wheezing	Y	P
Shortness of breath	Y	P
-with exertion	Y	P
-lying down	Y	P
Pain on breathing	Y	P
Bronchitis/Pneumonia	Y	P
Emphysema	Y	P
Tuberculosis	Y	P
Asthma	Y	P
Practice deep breathing?	Y	N

Cardiovascular ♦

Palpitations/flutter	Y	P
Chest tightness	Y	P
Chest pain/angina	Y	P
High blood pressure	Y	P
Low blood pressure	Y	P
High cholesterol	Y	P
Heart murmur	Y	P
Swelling of hands/feet/legs	Y	P
Cold hands/feet	Y	P
Varicose veins	Y	P
Deep leg pain	Y	P
Deep vein thrombosis	Y	P
Rheumatic fever	Y	P
Stroke	Y	P
Heart Disease	Y	P

Gastrointestinal ♦

Nausea	Y	P
Vomiting	Y	P
Bloating	Y	P
Flatulence(gas)	Y	P
Belching	Y	P
Abdominal pain	Y	P
Heartburn/GERD	Y	P
Trouble swallowing	Y	P
Jaundice (yellow skin)	Y	P
Liver disease	Y	P
Gallbladder stones/attack	Y	P
Ulcer	Y	P
Anal pain/itching	Y	P
Hemorrhoids	Y	P
Laxative use	Y	P

Bowel Movements ♦

How often?_____		
Loose stool/diarrhea	Y	P
Constipation	Y	P
Blood in stool	Y	P
Mucus in stool	Y	P
Undigested food in stool	Y	P
Black stool	Y	P
Straining or pain w/BM	Y	P
Greasy/fatty stool	Y	P

Urinary ♦

Pain on urination	Y	P
Increased urgency	Y	P
Increased frequency	Y	P
Blood in urine	Y	P
Wake to urinate	Y	P
Inability to hold urine	Y	P
Bladder infection/UTI	Y	P
Kidney disease	Y	P
Kidney stones	Y	P
Pelvic pain	Y	P

Female Reproductive ♀

Are you pregnant or lactating?	Y	N
Age menses began:_____		
Date of last period:_____		
# of days period lasts:_____		
Cycle length (e.g.28d):_____		
Are your cycles regular?	Y	N
Heavy flow	Y	P
Diminished flow	Y	P
Large clots	Y	P
Painful menses/cramps	Y	P
Bleeding b/t periods	Y	P
Facial hair growth	Y	P
PMS	Y	P
Describe:		
Menopause symptoms	Y	P
Describe:		
Age at menopause:_____		
Breast pain/tenderness	Y	P
Breast lumps	Y	P
Nipple discharge	Y	P
Yeast/vaginal infections	Y	P
Endometriosis	Y	P
Polycystic ovaries	Y	P
# of Pregnancies:_____		
# of Live Births:_____		
# Miscarriages/Stillbirths:_____		
Difficulty conceiving	Y	P
Future OB plans	Y	N ?
Sexually active?	Y	P
Practice safer sex?	Y	N
Sexual difficulties	Y	P
STDs	Y	P

Male Reproductive ♂

Testicular masses/swelling	Y	P
Testicular pain	Y	P
Prostate problems	Y	P
Hernias	Y	P
Discharge or sores	Y	P
Sexually active?	Y	P
Practice safer safe?	Y	N
Sexual difficulties	Y	P
STDs	Y	P

Musculoskeletal ♦

Joint pain/stiffness	Y	P
Muscle pain	Y	P
Muscle spasm/cramps	Y	P
Weakness	Y	P
Back problems	Y	P
Trauma/swelling	Y	P
Arthritis	Y	P
Osteoporosis	Y	P
Restless/jittery legs	Y	P

Neurologic ♦

Fainting	Y	P
Seizures/epilepsy	Y	P
Dizziness/vertigo	Y	P
-when standing up	Y	P
Numbness/tingling	Y	P
Loss of memory	Y	P
Problems walking	Y	P
Head injury/concussion	Y	P

Endocrine ♦

Cold/heat intolerance	Y	P
Difficult to ↑ weight	Y	P
Difficult to ↓ weight	Y	P
Excessive thirst	Y	P
Excessive hunger	Y	P
Hypoglycemic	Y	P
Diabetes/pre-diabetes	Y	P
Hypothyroid	Y	P
Hyperthyroid	Y	P
Cushings or Addisons	Y	P

Immune/Blood ♦

Anemia	Y	P
Easy bleeding/bruising	Y	P
Chronic/frequent infection	Y	P
Seasonal allergies/hayfever	Y	P
Frequent infection as child	Y	N
Swollen glands/nodes	Y	P
History of tick bites	Y	P
Breastfed as baby?	Y	N
Epstein Barr virus	Y	P
Mononucleosis	Y	P
Helicobacter pylori	Y	P
HIV/AIDS	Y	P

Other ♦

Mental fog	Y	P
Panic attacks	Y	P
Mood swings	Y	P
Alcoholism	Y	P
Drug dependency	Y	P
Eating disorder	Y	P
Alzheimer's/dementia	Y	P
Attention deficit	Y	P
Depression	Y	P
Seasonal depression	Y	P

Diet and Lifestyle

Please circle # corresponding to use: **0=never 1=seldom (4x/month or less) 2=moderate (1-4/week) 3=frequent (5-7x/week)**

Coffee	0	1	2	3	Fruit	0	1	2	3	Soy (tofu, milk, etc.)	0 1 2 3
Tea (type:)	0	1	2	3	Vegetables	0	1	2	3	Fish/Seafood	0 1 2 3
Soda	0	1	2	3	Beans/legumes	0	1	2	3	Poultry	0 1 2 3
Alcohol	0	1	2	3	Nuts/seeds	0	1	2	3	Red Meat	0 1 2 3
Fruit Juice	0	1	2	3	White flour products	0	1	2	3	Eggs	0 1 2 3
Snack foods (chips, etc)	0	1	2	3	Whole grains	0	1	2	3	Seaweeds	0 1 2 3
Sweets (desserts/candy)	0	1	2	3	Potatoes	0	1	2	3		
Fast food	0	1	2	3	Brown/white rice	0	1	2	3	Cigarettes/Tobacco	0 1 2 3
Artificial sweeteners*	0	1	2	3	Milk/cheese/cream	0	1	2	3	# of cigs/day For how long?	
Water	cups/oz per/day				Yogurt	0	1	2	3	Recreational drugs	0 1 2 3

**Includes aspartame/nutrasweet/sorbitol/sucralose/Splenda found in diet sodas, candy, and used in beverages for sweetening*

Do you follow any specific type of diet? If so, please describe? (include foods avoided like gluten or dairy, "named" diets like Atkin's, vegetarian/vegan, whole foods diet, etc.)

Please list a typical breakfast, lunch, dinner, and snack for you:

Breakfast	
Lunch	
Dinner	
Snack	

List any food cravings _____

Average hours of sleep/night? _____ Normal Bedtime _____ Normal waking time _____

Please check those that apply:		
◊Trouble falling asleep initially	◊Sensitive sleeper, wake easily	◊Pain or physical disorder prevents sleep
◊Can't fall back to sleep if I wake up	◊Grinding teeth	◊Reflux/heartburn while in bed
◊Frequent waking in night ◊to urinate	◊Snoring/gasping for air	◊Wake unrefreshed/irritable
◊Racing thoughts preventing sleep	◊Excessive dreaming	◊Waking too early in AM
	◊Can't remember dreams	◊Sleepy during day

Rate your stress level. *Circle.* **1 2 3 4 5** (most stress) What do you do to relieve stress? _____

Frequency of exercise per week? ◊Never ◊1-3x/week ◊3-5x/week ◊5-7x/week Other:

What types of exercise? (for ex: elliptical, skiing, weight training, etc.) _____

Do you have trouble getting enough exercise or sticking to a routine? _____

Rate your energy level. Circle **1 2 3 4 5** (most energy) My energy is best in: ◊Morning ◊Afternoon ◊Evening/Night

My energy is worst in: ◊Morning ◊Afternoon ◊Evening/Night

Environment

Have you had any toxic environmental exposures in your lifetime? ◊Yes ◊No ◊Maybe

Explain.

Are you exposed to any toxins or chemicals in your hobbies/work on a frequent basis? (pesticides w/gardening, lead solder, etc) ◊Yes ◊No

Explain.

How often do you buy organic produce and products? *Circle.* Never Sometimes Often Always

How often do you buy hormone free, antibiotic free animal products? *Circle.* Never Sometimes Often Always

Have you ever had problems with mold at work or at home? ◊Yes ◊No

Have you ever lived in a house with brand new carpet, new furniture, or during or following a remodel? ◊Yes ◊No

Work and Social History

Are you: ◊Single ◊Married ◊Partnered ◊Separated ◊Divorced ◊Other

Who do you live with: ◊Alone ◊Partner/Spouse ◊Relatives ◊Friends ◊Kids ◊Other

Do you feel safe in your living environments? (home, work, school) ◊Yes ◊No

Do you have children? If yes, please list names and ages _____

Are you content with your relationships & support system? Who do you turn to for support?

What do you do for work? _____

How do you feel about your work/career? _____ # of hours you work per week? _____

Have you ever traveled outside the U.S.? If so, where? _____

How much time do you spend outside in a week? _____ Hobbies/Interests _____

Please check any of the following emotions that have **predominated** lately:

◊joyful ◊peaceful ◊excited ◊motivated ◊sad ◊stressed ◊angry ◊hurt ◊abandoned ◊bored ◊worried ◊irritable ◊grieving ◊depressed ◊unmotivated ◊fearful ◊anxious ◊trauma-related stress ◊abuse-related stress ◊other:

What brings you joy in life?

What are you current challenges/frustrations in life?

If there is anything else you would like me to know about you and your health, please use the space below:

Thank you for your time! Once completed, please do one of the following:

- **fax to 888-464-0907**
- **scan document and email to chantewiegand.nd@gmail.com**

By reviewing ahead of time, I will be able to make the most of your first visit. If unable to do so, please bring with you to your first visit, along with any copies of recent lab reports, and bottles of supplements you are currently taking.