Ohio Naturopathic Wellness Center
755 Boardman-Canfield Rd, Suite D3 • Boardman, OH 44512
(330) 729-1350 • www.OhioND.com

DATE:_____

PATIENT PROFILE

LEGAL NAME _____/_____/_____
LAST NAME **FIRST NAME** **MIDDLE INITIAL**

PREFERRED NAME _____ **AGE** _____ **DATE OF BIRTH (DOB)** _____ **GENDER**_____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

EMAIL ADDRESS _____ **SIGN ME UP FOR FREE NEWSLETTER ( ) YES ( ) NO**

HOME PHONE _____ **WORK PHONE** _____ **CELL PHONE** _____

OCCUPATION _____ ☐ **FULL TIME** ☐ **PART TIME** ☐ **RETIRED** ☐ **STUDENT**

EMERGENCY CONTACT _____ **RELATIONSHIP** _____

ADDRESS _____ **PHONE** (H)_____(W)_____(M) _____

INSURANCE COMPANY _____ **POLICY #** _____

INSURANCE ADDRESS _____

NAME OF PERSON INSURED _____

PRIMARY CARE PROVIDER (PCP)_____ **LAST TIME SEEN BY PCP**_____

ADDRESS _____ **PHONE** _____

WHOM MAY WE THANK FOR REFERRING YOU?_____

_____

We understand that this is a lengthy questionnaire and appreciate the time it takes to fill out. Please answer the questions as thoroughly as possible as this will help the practitioner gain a complete picture of your condition. Thank you!

What health problems do you want to talk about today? List in order of Importance.

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

HEALTH INFORMATION

HOSPITALIZATIONS/SURGERIES: (Dates and type of illness/operation)

_____

_____

KNOWN ALLERGIES: (to medications, foods, pollens, etc.)

_____

MEDICATIONS (include prescription and non-prescription items, dosage and frequency of use.)

_____

_____

_____

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SUPPLEMENTS: (include vitamins, herbs, minerals, etc.)

_____

_____

_____

SOCIAL HISTORY

Occupation _____ Years of Education? _____

Current Employment Status? ☐ Retired ☐ Unemployed ☐ Homemaker ☐ Employed

Past Occupation (s)? _____

Are you Disabled? ☐Yes ☐No Reason? _____

History of Physical, Emotional or Sexual Abuse? ☐Yes ☐No

Marital Status? ☐Single ☐Married ☐Divorced ☐ Separated ☐ In Significant Relationship (unmarried) ☐ Widow

Primary interests, hobbies, or activities: _____

_____

Do you get regular exercise? ☐Yes ☐No. What form? _____

How often? _____

Do you drink alcohol? If so, how much, how often, and what kind? _____

_____

Do you use other recreational drugs? If so, what kind and how often? _____

_____

Do you use tobacco? If so, what kind, how much, and for how long have you used it? _____

_____

Do you drink coffee? If so, how much? _____

IMMUNIZATIONS HISTORY

Check the immunization you have received and the approximate year it was last given:

Chicken Pox	☐Yes ☐No Year _____	Measles	☐Yes ☐No Year _____
Diptheria	☐Yes ☐No Year _____	Mumps	☐Yes ☐No Year _____
Hepatitis A	☐Yes ☐No Year _____	Pneumococcal	☐Yes ☐No Year _____
Hepatitis B	☐Yes ☐No Year _____	Rubella	☐Yes ☐No Year _____
HPV	☐Yes ☐No Year _____	Shingles	☐Yes ☐No Year _____
Influenza (Flu)	☐Yes ☐No Year _____	Tetanus (last 10 yrs)	☐Yes ☐No Year _____

Any adverse reactions to Vaccines current or past? ☐Yes ☐No

Explain _____

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Stress

Current Level of Stress? ☐ Low ☐ Moderate ☐ High

Source of Stress? ☐ Work ☐ Financial ☐ Family/Relationship ☐ Other

Perspiration

I sweat/perspire? ☐ Seldom ☐ Moderately ☐ Often ☐ Excessively

I perspire in the area(s) of? ☐ Head ☐ Entire Body ☐ Under arms ☐ Other _____

Hot/Cold/Body Temp

Do you have the following? ☐ Chills ☐ Fever ☐ Chronic fever ☐ Alternating Chills with Fever ☐ Night Sweats
☐ Warm hands and feet ☐ Cold hands and feet ☐ Hot flashes in the afternoon or evening
Describe your body temperature normally? ☐ Chilly ☐ Warm ☐ Neutral

HEENT

Which best describes your Headaches if applicable? ☐ Worse with fatigue ☐ One-sided ☐ At temples ☐ At forehead
☐ At Top of the head ☐ At back of head ☐ Dizziness
Please mark any of the following that apply: ☐ Dry eyes ☐ Watery eyes ☐ Blurred vision ☐ Red eyes ☐ Floaters
☐ High pitched ringing in the ears ☐ Low pitched ringing in the ears ☐ Difficulty hearing ☐ Vertigo
☐ Dry mouth ☐ Difficulty swallowing ☐ Sensation of something stuck in throat ☐ Hoarseness
Which tastes if any do you have in your mouth? ☐ Bitter ☐ Sweet ☐ Sour ☐ Salty ☐ Pungent ☐ Metallic

Chest

Please check all, if any, that apply: ☐ Chest Pain ☐ Palpitations ☐ Heavy Sensation in Chest ☐ Shortness of Breath
☐ Asthma ☐ Wheezing ☐ Frequent Respiratory Infections ☐ Dry Cough ☐ Productive Cough

Diet

I would describe my diet as? (Check all that Apply)
☐ Standard American Diet ☐ Fast Food and Processed Foods ☐ Organic Whole Foods Diet ☐ Meat and Potatoes
☐ Vegetarian ☐ Gluten-Free ☐ Dairy-Free ☐ Balanced Whole Foods, Lean Proteins & Vegetables

How many meals do you generally eat per day? _____ How many snacks? _____

What kinds of foods make up your primary diet? _____
What kinds of foods do you usually exclude form your diet? _____

_____

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Thirst/Water Intake

Thirst? ☐ Low ☐ Moderate ☐ High I prefer: ☐ Cold drinks ☐ Warm drinks ☐ Room temperature
How many cups (12 oz.) of water do you drink per day? ☐ 1-4 ☐ 5-8 ☐ 8-10 ☐ More than 10
Do you drink caffeine? ☐ No ☐ Yes If yes, how many 12oz cups per day? _____
Do you drink alcohol? ☐ No ☐ Yes If yes, how many 12oz cups per day/week/Month? _____

Digestion/Appetite

Describe your appetite? ☐ Low ☐ High ☐ Normal
I crave the following foods? ☐ Sugary ☐ Salty ☐ Fatty ☐ Cold ☐ Hot ☐ Spicy ☐ Sour
I suffer from ☐ Gas ☐ Bloating ☐ Abdominal pain/discomfort ☐ Belching ☐ Acid Reflux

Stools

Do you have? ☐ Constipation ☐ Loose Stools with undigested food ☐ Loose stools (before menses) ☐ Diarrhea
☐ Sticky stools ☐ Early morning diarrhea ☐ Alternating diarrhea and constipation ☐ Hard stools

Urination

Do you suffer from ☐ Painful urination ☐ Incontinence ☐ Urinary frequency ☐ Frequent UTI ☐ Kidney stones
☐ Diminished force of urinary stream ☐ Difficulty starting or stopping flow
Urine color is ☐ Dark ☐ Pale yellow ☐ Clear

Pain

Do you have Pain? ☐ Yes ☐ No If yes, what is the location of pain? _____
Which describes your pain? ☐ Better with heat ☐ Better with pressure ☐ Worse with heat ☐ Worse with pressure
☐ Worse with damp weather ☐ Pain moves from place to place ☐ Pain worse with fatigue
☐ Pain associated with bloating or distention ☐ Sharp ☐ Stabbing ☐ Burning ☐ Dull ☐ Achy
Do you experience numbness or tingling in the hands or feet? ☐ No ☐ Yes If yes, explain_____

Sleep

Do you have the following? ☐ Difficulty falling asleep ☐ Waking at night due to heat ☐ Nightmares
☐ Waking or difficulty falling asleep due to mind racing ☐ Insomnia of unknown reason ☐ Unrefreshing sleep

Energy

Typically my energy level is (0-10/10 ten is great energy, zero is no energy)_____
I am ☐ able to accomplish daily tasks ☐ struggle to accomplish daily tasks ☐ unable to accomplish daily tasks

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EMOTIONS/MOOD

Do you have the following? ☐ Depression ☐ Anxiety ☐ Irritability ☐ Mania ☐ Anger and aggression
☐ Other_____

FEMALES

If Menstruating:
LMP _____Days between Cycles? _____How long do your periods Last? _____
Clots? ☐ No ☐ Yes If yes, size? ☐ Dime ☐ Nickel ☐ Quarter ☐ Half Dollar ☐ Larger than ½ Dollar
Cramps? ☐ Mild ☐ Moderate ☐ Severe Pain Quality? ☐ Stabbing ☐ Burning ☐ Achy ☐ Bear down Sensation
Do you have vaginal Discharge? ☐ No ☐ Yes
If **yes**, is it? ☐ Thin ☐ Thick ☐ Clear ☐ White ☐ Yellow ☐ Scanty ☐ Copious
Color of Menses? ☐ Dark Red ☐ Bright Red
Do you have PMS symptoms? ☐ No ☐ Yes if yes, answer the questions below:
Premenstrual symptoms before your period (Mark below): (Grade intensity – 1=mild, 2=moderate, 3=severe)
___ Breast Tenderness ___ Bloating ___ Skin ___ Mood Changes _____
___ Headache ___ Cramping ___ Diarrhea ___ Appetite Changes _____
___ Low Back Pain ___ Constipation ___ Other
PMS symptoms occur? ☐ One week prior ☐ 2 weeks prior ☐ Few days prior ☐ Other _____
Do the above premenstrual symptoms get better with your period? ☐ No ☐ Yes
Are You Post-Menopausal? ☐ No ☐ Yes
Do you have the following symptoms now?
Hot flashes? ☐ No ☐ Yes Night Sweats? ☐ No ☐ Yes Insomnia? ☐ No ☐ Yes
Vaginal Dryness? ☐ No ☐ Yes Low Libido? ☐ No ☐ Yes

HISTORY OF EXAMS

Type the last year of the exam and the finding (normal or abnormal)

Last Eye Exam: Year _____ ☐Normal ☐Abnormal

Last Dental Exam: Year _____ ☐Normal ☐Abnormal

Last Blood work: Year _____☐Normal ☐Abnormal

Last Colonoscopy: Year _____ ☐Normal ☐Abnormal

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FAMILY HISTORY

Check Yes or No for Blood Relatives

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Alcoholism			Gout			Seizure or epilepsy		
Anemia			Hemophilia			Sickle Cell Anemia		
Asthma			Hay Fever			Skin Disorders		
Cancer			Heart Disease			Stroke		
Diabetes			High Blood Pressure			Thyroid Disorders		
Gallbladder Disease			Hypoglycemia			Tuberculosis		
Glaucoma			Mental Illness			Venereal Disease		

Any other significant family health problems? _____

_____

PAST MEDICAL HISTORY (YOU)

Please check all that apply regarding **Your** personal health history

Current	Past	
☐	☐	Anxiety
☐	☐	Alcoholism
☐	☐	Allergies (Hayfever)
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Autoimmune Disorder
☐	☐	Blood Clot (Leg)
☐	☐	Blood Clot (Lung)
☐	☐	Blood Transfusion
☐	☐	Breast Lump (Benign)
☐	☐	Cancer Breast
☐	☐	Cancer Colon
☐	☐	Cancer Ovarian
☐	☐	Cancer Prostate
☐	☐	Cancer
Other _____		
☐	☐	Colitis

Current	Past	
☐	☐	Crohn's Disease
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Diverticulosis
☐	☐	Gastroesophageal Reflux (GERD)
☐	☐	Gallbladder Disease
☐	☐	Gout
☐	☐	Headaches (General)
☐	☐	Headaches (Migraines)
☐	☐	Heart Disorders
☐	☐	Herpes Genitalis
☐	☐	High Blood pressure
☐	☐	High Cholesterol
☐	☐	Hypoglycemia
☐	☐	Injury (Serious)
☐	☐	Irritable Bowel Syndrome (IBS)

Current	Past	
☐	☐	Kidney Stones
☐	☐	Liver Disorders
☐	☐	Multiple Sclerosis
☐	☐	Neuropathy
☐	☐	Osteoporosis/Osteopenia
☐	☐	PMS
☐	☐	Seizures
☐	☐	Skin Disorders
☐	☐	Sleep Apnea
☐	☐	Stroke
☐	☐	Thyroid (Hashimoto's)
☐	☐	Thyroid Disorders (Hypo)
☐	☐	Thyroid Disorder (Hyper)
☐	☐	Tuberculosis
☐	☐	Ulcerative Colitis (UC)
☐	☐	Venereal Disease

Other _____

_____

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REVIEW OF SYSTEMS (APPLIES TO YOUR HEALTH)

HEAD

Current	Past	
☐	☐	Bells Palsey
☐	☐	Facial Pain
☐	☐	Hair Loss
☐	☐	Headaches
☐	☐	Jaw Pain
☐	☐	Migraines
☐	☐	TMJ Pain

EARS

Current	Past	
☐	☐	Change in Hearing
☐	☐	Drainage
☐	☐	Hearing Loss
☐	☐	Infections
☐	☐	Itching
☐	☐	Pain/Earache
☐	☐	Pressure
☐	☐	

EYES

Current	Past	
☐	☐	Blurred vision
☐	☐	Cataracts
☐	☐	Dryness
☐	☐	Excessive Tearing/Watering
☐	☐	Glasses/Contacts
☐	☐	Glaucoma
☐	☐	Itching
☐	☐	Night Blindness
☐	☐	Redness
☐	☐	Pain

NOSE

Current	Past	
☐	☐	Allergies
☐	☐	Congestion
☐	☐	Frequent Cold & Flus
☐	☐	Loss or Change of Smell
☐	☐	Nose Bleeds
☐	☐	Runny Nose
☐	☐	Sinusitis

THROAT

Current	Past	
☐	☐	Difficulty Swallowing
☐	☐	Hoarseness/Loss of Voice
☐	☐	Itchiness
☐	☐	Pain
☐	☐	Post-Nasal Drip
☐	☐	Sore Throat
☐	☐	Recurrent Sore Throat
☐	☐	Strep Throat
☐	☐	Recurrent Strep Throat
☐	☐	Swelling
☐	☐	Tightness/Pressure
☐	☐	Tonsillitis

MOUTH

Current	Past	
☐	☐	Canker Sores
☐	☐	Cold Sores
☐	☐	Gingivitis
☐	☐	Gum /Periodontal Disease
☐	☐	Loss of Taste
☐	☐	Sore on mouth/lips/gums
☐	☐	Strange Taste In Mouth

NEURO

Current	Past	
☐	☐	Concussion
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Loss of Balance
☐	☐	Memory Loss
☐	☐	Night Headaches
☐	☐	Paralysis
☐	☐	Seizures
☐	☐	Tingling/Numbness
☐	☐	Tremors
☐	☐	Vertigo

OTHER CONDITIONS

Current	Past	
☐	☐	Diabetes
☐	☐	Frequent Infections/ Cold
☐	☐	Gallbladder Disease
☐	☐	Gout
☐	☐	Headaches (General)
☐	☐	Headaches (Migraines)
☐	☐	Heart Disorders
☐	☐	Herpes Genitalis
☐	☐	High Blood pressure
☐	☐	High Cholesterol
☐	☐	Hypoglycemia
☐	☐	Injury (Serious)
☐	☐	Liver Disorders
☐	☐	Multiple Sclerosis
☐	☐	Neuropathy
☐	☐	Osteoporosis/Osteopenia
☐	☐	PMS
☐	☐	Recurrent Yeast Infections
☐	☐	Tuberculosis

NECK

Current	Past	
☐	☐	Enlarged Thyroid
☐	☐	Swollen Glands
☐	☐	Thyroid (Hashimoto's)
☐	☐	Thyroid Disorders (Hypo)
☐	☐	Thyroid Disorder (Hyper)

HEART/CARDOVASCULAR

Current	Past	
☐	☐	Blood Clots
☐	☐	Blood Pressure - High
☐	☐	Blood Pressure - Low
☐	☐	Chest Pain
☐	☐	Chest Tightness
☐	☐	Edema
☐	☐	Heart Murmur
☐	☐	Irregular Heart Beat
☐	☐	Palpitations
☐	☐	Peripheral Vascular Disease
☐	☐	Stroke

LUNGS

Current	Past	
☐	☐	Asthma
☐	☐	Cough - Dry
☐	☐	Cough - Wet
☐	☐	Cough - Recurrent/Chronic
☐	☐	Cough up Blood
☐	☐	Cough up Phlegm
☐	☐	COPD
☐	☐	Emphysema
☐	☐	Respiratory Infections
☐	☐	Shallow Breathing
☐	☐	SOB
☐	☐	Wheezing

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ABDOMEN/DIGESTION

Current	Past	
☐	☐	Alternating Constipation/Diarrhea
☐	☐	Bad Breath
☐	☐	Belching
☐	☐	Bloating
☐	☐	Blood in Stools
☐	☐	Constipation
☐	☐	Crohn's Disease
☐	☐	Diarrhea
☐	☐	Diverticulosis
☐	☐	Food Cravings
☐	☐	Gas
☐	☐	Gastroesophageal Reflux (GERD)
☐	☐	Heartburn
☐	☐	Hemorrhoids
☐	☐	Indigestion
☐	☐	Little Appetite
☐	☐	Loose Stools
☐	☐	Nausea
☐	☐	Strong Appetite
☐	☐	Strong Smelling Stools
☐	☐	Ulcerative Colitis (UC)
☐	☐	Vomiting
☐	☐	Weight Loss

HAIR/NAILS

Current	Past	
☐	☐	Brittle
☐	☐	Dry
☐	☐	Hair Loss

URINARY/KIDNEY

Current	Past	
☐	☐	Bladder/Kidney Infections
☐	☐	Blood in Urine
☐	☐	Cloudy Urine
☐	☐	Difficulty Starting Urination
☐	☐	Frequency
☐	☐	Kidney Stones
☐	☐	Leaking Urine/Incontinence
☐	☐	Pain w/Urination
☐	☐	Urgency

MUSCULAR/SKELETAL

Current	Past	
☐	☐	Arthritis
☐	☐	Back Pain
☐	☐	Carpel Tunnel
☐	☐	Gallbladder Stones/Disease
☐	☐	Hand/Wrist Pain
☐	☐	Herniated Disc(s)
☐	☐	Hernia
☐	☐	Joint Pain
☐	☐	Joint Stiffness
☐	☐	Muscle Cramps
☐	☐	Muscle Pain
☐	☐	Neck Pain
☐	☐	Osteoporosis
☐	☐	Rectal Bleeding
☐	☐	Sciatica
☐	☐	Shoulder Pain
☐	☐	Tremors
☐	☐	Weakness

PERIPHERAL VASCULAR/EXTREMITIES

Current	Past	
☐	☐	Burning Hands/Feet
☐	☐	Blood Clots
☐	☐	Cold Hands/Feet
☐	☐	Numbness
☐	☐	Puffy Eyes
☐	☐	Raynaud's
☐	☐	Swelling Hands/Feet
☐	☐	Tingling
☐	☐	Varicose Veins

ENERGY

Current	Past	
☐	☐	Chronic Fatigue Syndrome
☐	☐	Fatigue

SLEEP

Current	Past	
☐	☐	Difficulty Falling Asleep
☐	☐	Difficulty Staying Asleep
☐	☐	Grinding Teeth
☐	☐	Nightmares
☐	☐	Restlessness
☐	☐	Restlessness Leg Syndrome
☐	☐	Sleep Apnea
☐	☐	Snoring
☐	☐	Vivid Dreams

WEIGHT

Current	Past	
☐	☐	Emotional Eating
☐	☐	Weight Gain
☐	☐	Weight Loss
☐	☐	Desire for Weight Gain
☐	☐	Desire for Weight Loss

SKIN

Current	Past	
☐	☐	Abnormal Sweating
☐	☐	Acne
☐	☐	Difficult/Poor Wound Healing
☐	☐	Dryness
☐	☐	Easy Bruising
☐	☐	Eczema
☐	☐	Hives
☐	☐	Itching
☐	☐	Psoriasis
☐	☐	Rashes

MENTAL/EMOTIONAL

Current	Past	
☐	☐	Aggressive Behavior
☐	☐	Anxiety
☐	☐	Bi-Polar
☐	☐	Depression
☐	☐	Difficulty Concentrating
☐	☐	Eating Disorder
☐	☐	High Strung/Tense
☐	☐	Irritability
☐	☐	Manic Behavior
☐	☐	Mood Swings
☐	☐	Obsessive/Compulsive Thoughts
☐	☐	Panic Attacks
☐	☐	Poor Focus
☐	☐	Substance Abuse
☐	☐	Suicidal Thoughts