

Makai Naturopathic Center

468 Central Ave. Dover, NH 03820 Ph: 603-742-4114



PERSONAL INFORMATION:

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Telephone (home) _____ (work) _____
E-mail _____ Date of Birth _____
Age _____ Gender Female ___ Male ___
Relationship Status Single ___ Married ___ Divorced ___ Widowed ___
Occupation _____ Hours per week ___ Employer _____
In case of emergency, please notify _____
Relationship _____ Phone _____

HEALTH OVERVIEW

Name of current general practitioner _____
When was your last visit and for what? _____
Do you have any known contagious disease at this time? Y N If yes, what? _____
What is the main reason for your visit today? _____

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

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

How did you hear about our clinic? _____

Would you like to be informed by email of upcoming classes and events at our clinic?
Yes ___ No ___

Cancellation Policy:

I understand that I am responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

Consent:

I hereby consent to receive treatment by the practitioners at Makai Naturopathic Center. I understand that this consent is voluntary and may be revoked by me at any time. I understand the fee structure, and accept responsibility for payment.

Signature _____ Date _____

HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY

Do you have a family history of any of the following (Please Circle)?

Cancer	Diabetes	Heart Disease
Kidney Disease	Epilepsy	High Blood Pressure
Tuberculosis	Stroke	High Cholesterol
Asthma/Hayfever/Hives	Arthritis	Anemia

Any other relevant family history? _____

What is your ethnic heritage? _____

CHILDHOOD ILLNESSES

Scarlet Fever	Diphtheria	Rheumatic Fever
Mumps	Measles	German Measles

IMMUNIZATIONS

Please place a check next to all that apply.

<input type="checkbox"/>	Polio	<input type="checkbox"/>	Pertussis
<input type="checkbox"/>	Tetanus: When? _____	<input type="checkbox"/>	Diphtheria
<input type="checkbox"/>	Measles/Mumps/Rubella	<input type="checkbox"/>	Travel Related:

HOSPITALIZATIONS, SURGERIES & IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKG's have you had?

_____ year: _____ year: _____
_____ year: _____ year: _____
_____ year: _____ year: _____
_____ year: _____ year: _____

ALLERGIES & SENSITIVITIES

Are you allergic or hypersensitive to:

Medications: _____

Foods: _____

Environmental or chemical agents: _____

CURRENT MEDICATIONS

Do you take or use (Please circle)?

Laxatives	Pain relievers	Antacids
Cortisone	Appetite suppressants	Antibiotics
Tranquilizers	Thyroid medication	Sleeping pills

Please list any prescription medications, over the counter medications, vitamins or supplements you are taking.

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

GENERAL HEALTH

Height _____ Weight _____ lbs. Weight 1 year ago _____ lbs.

Max. weight _____ lbs. Min. Adult weight _____ lbs. When _____

When during the day is your energy the best? _____ worst? _____

How many times per week do you exercise? _____

What do you do for exercise? _____

How many hours of sleep do you get each night? _____ Is the sleep restful? _____

If no, please explain. _____

REVIEW OF SYSTEMS

Please check any of the following conditions you currently have (C box), have had in the past (P box), or have never had (N box). Please also check if you feel any of the following are a significant part of your medical history.

LIFESTYLE

C	P	N	
			Alcohol
			Marijuana
			Drugs
			Treated for drug dependence
			Stress

C	P	N	
			History of smoking
			How many packs/day?
			How many years?
			Occupational hazards
			Any major traumas

MENTAL/EMOTIONAL

C	P	N	
			Treated for emotional problems
			Mood swings
			Considered/attempted suicide
			Poor concentration

C	P	N	
			Depression
			Anxiety or nervousness
			Tension
			Memory problems

ENDOCRINE

C	P	N	
			Hypothyroid
			Hyperthyroid
			Hypoglycemia
			Excessive thirst
			Seasonal depression

C	P	N	
			Heat or cold intolerance
			Diabetes
			Excessive hunger
			Fatigue

IMMUNE

C	P	N	
			Chronic fatigue syndrome
			Chronically swollen glands
			Reactions to vaccines

C	P	N	
			Chronic infections
			Slow wound healing
			Reactions to immunizations

NEUROLOGIC

C	P	N	
			Seizures
			Muscle weakness
			Tremor
			Vertigo or dizziness

C	P	N	
			Heat or cold intolerance
			Numb/Tingling extremities
			Loss of memory
			Difficulty concentrating

SKIN

C	P	N	
			Rashes
			Acne, boils
			Color change
			Lumps

C	P	N	
			Eczema, hives
			Itching
			Perpetual hair loss
			Night sweats

HEAD

C	P	N	
			Headaches
			Migraines

C	P	N	
			Head injury
			Jaw/TMJ problems

EARS

C	P	N	
			Impaired hearing
			Earaches

C	P	N	
			Ringing in the ears/ Tinnitus
			Dizziness

EYES

C	P	N	
			Spots in eyes
			Impaired vision
			Blurriness
			Color blindness
			Double vision

C	P	N	
			Cataracts
			Glasses or contacts
			Eye strain/pain
			Tearing or dryness
			Glaucoma

NOSE & SINUSES

C	P	N	
			Frequent colds
			Stuffiness or post-nasal drip
			Sinus problems

C	P	N	
			Nose bleeds
			Hayfever
			Loss of smell

MOUTH & THROAT

C	P	N
		Frequent sore throat
		Teeth grinding
		Gum problems
		Dental cavities

C	P	N
		Copious saliva
		Sore tongue/lips
		Hoarseness
		Jaw clicks

NECK

C	P	N
		Lumps
		Goiter

C	P	N
		Swollen glands
		Pain or stiffness

RESPIRATORY

C	P	N
		Cough
		Spitting up blood
		Asthma
		Pneumonia
		Emphysema
		Pain on breathing
		Shortness of breath at night

C	P	N
		Sputum
		Wheezing
		Bronchitis
		Pleurisy
		Difficulty breathing
		Shortness of breath
		Shortness of breath lying down

CARDIOVASCULAR

C	P	N
		Heart disease
		High/low blood pressure
		Blood clots
		Phlebitis
		Rheumatic fever
		Swelling in ankles

C	P	N
		Angina
		Murmurs
		Fainting
		Palpitations/Fluttering
		Chest pain
		High cholesterol

GASTROINTESTINAL

C	P	N
		Trouble swallowing
		Reflux
		Heartburn
		Vomiting blood
		Nausea
		Change in appetite
		Vomiting
		Belching or passing gas
		Ulcer
		Hemorrhoids

C	P	N
		Constipation
		Diarrhea
		Blood with stool
		Change in bowel movements
		Abdominal pain or cramps
		Gallbladder disease
		Black stools
		Colon polyps
		Jaundice
		Liver disease

URINARY

C	P	N
		Pain on urination
		Increased frequency
		Frequent infections

C	P	N
		Frequency at night
		Inability to hold urine/urgency
		Kidney stones

MUSCULOSKELETAL

C	P	N
		Joint pain or stiffness
		Broken bones
		Muscle spasms or cramps

C	P	N
		Arthritis
		Weakness
		Sciatica

BLOOD/PERIPHERAL VASCULAR

C	P	N
		Easy bleeding or bruising
		Deep leg pain
		Varicose veins

C	P	N
		Anemia
		Cold hands/feet
		Thrombophlebitis

FEMALE REPRODUCTION/BREASTS

Age of first menses _____ Length of cycle _____
 Duration of menses _____ Age of last menses (menopausal) _____
 Date of last annual exam/PAP (M/D/Y) _____

C	P	N
		Irregular cycles
		Bleeding between cycles
		Cramping with menses
		Premenstrual syndrome
		Clotting
		Heavy or excessive flow
		Vaginal discharge
		Menopausal symptoms
		Breast lumps
		Breast pain/tenderness
		Nipple discharge

C	P	N
		Abnormal PAP
		Cervical dysplasia
		Endometriosis
		Ovarian cysts
		Uterine fibroids
		Sexually active
		Painful intercourse
		Sexual difficulties
		Sexually transmitted disease
		Birth control: type _____
		Difficulty conceiving

Number of pregnancies _____ Number of live births _____
 Number of miscarriages _____ Number of abortions _____
 Do you do a self breast exam? _____ Have you had a hysterectomy? _____

MALE REPRODUCTION

C	P	N
		Hernias
		Testicular masses
		Testicular pain
		Prostate disease
		Sexually active

C	P	N
		Sexually transmitted disease
		Discharge or sores
		Impotence
		Premature ejaculation
		Birth Control: type _____

Welcome! We look forward to working with you to achieve your health goals.