Erica Campbell, ND

Health History Summary

Date____________________

Name____Age_____Birthday________________Blood Type_____
Address____City_______________State_______Zip_________
Email Address ____
Phone (home)______________________(work)_______________________(cell)____________________
Occupation_________________________________(full/part time) Employer______________________
Insurance Co. _______________________________Policy #_______________Soc. Sec. #________________
Address____City_______________State_______Zip_________
Nearest Relative_______________________________Relationship______________Phone_______________
Emergency Contact____________________________Relationship______________Phone_______________
Last physician or health practitioner seen? ________________________________When?______________
When last blood testing was done?________________What kind?____________________________
Who referred you to our office?____

Your Current Health Problems

What is your main reason for coming in? ____
If you have a specific health condition please describe in detail.

____
____
____
____
____

When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation? ______________________________
____
____
____

List in order of importance other health problems that are troubling you:

1. ____Length of time___________
2. ____Length of time___________
3. ____Length of time___________
4. ____Length of time___________

How long has your main problem been troubling you? _______________________________
Is your current "main problem" getting [better, worse, same] and for how long? ______________________
____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist, or other alternative health practitioner for your current problem? [yes, no]
What was the therapy and what were the results? ____

Your Health History

The general state of your health is [excellent, good, average, fair, poor]
On average describe your energy level from 1-10 ________(10 is highest, 1 is lowest)
When during the day is your energy the best?____________ Worst?______________
What is your current approximate Weight? __________ Height?___________ Weight 1yr ago__________
As an adult what has been your max weight (not including pregnancy)__________ minimum __________

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Please circle the most significant one.

1. ____ Date__________
2. ____ Date__________
3. ____ Date__________
4. ____ Date__________
5. ____ Date__________

Are you currently working with a professional counselor, psychologist, social worker, pastor, or other therapist?_________ Have you in the past? ____________
Are you currently working with a Doctor of conventional medicine? (MD or DO)
Name____

What are your current conventional treatments?

____
____

Mark any childhood illnesses have you had?

Measles________	Mumps_________	Chickenpox_________	Whooping cough________
Polio__________	Diphtheria________	Rheumatic fever_______	Scarlet fever___________
Smallpox_______	Typhoid fever______	Tuberculosis__________	Mono______ How long? ___

Previous surgeries and hospitalizations, including dates.

Surgery	Date
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Which of the following do you currently use? (Amount – how often, how much and how long)

Alcohol____________________	Tobacco____________________
Hormones____________________	Coffee____________________
Cortisone____________________	Laxatives____________________
Sedatives____________________	Antacids____________________

Do you have any allergies to any drugs, herbs, foods, animals or other? (Yes/No)

____
____

Medications (Please give full name, dosage and how long you have been taking the medication)

Name	Dose	When / How often

Vitamins / Herbs	Dose	When / How often

Family History

Please list ages, health problems and if deceased, cause of death:

	Living (age)	Died (age)	Health Problems
Your Mother			
Your Father			
Your Brothers			
Your Sisters			
Grandma & Grandpa			
Mother's Mom			
Mother's Dad			
Father's Mom			
Father's Dad			

What is your nationality? (Please list all backgrounds and give approximate %)

____

You currently live with? Spouse__ partner__ friends__ children__ alone__

Are you? Married__ divorced__ widowed__ single__ in a supportive relationship__

What is your current level of education? ____________________Are you satisfied with this? (Yes/No)

Do you have any children?____ How many?____ Ever had Toxemia during pregnancy? (Yes/No)

Do your children have any health problems?____________________

Do you have any relatives (aunt, uncle or grandparents) who have had any of the following?

___allergies ___arthritis ___asthma ___cancer ___skin disease

___anemia ___depression ___diabetes ___heart attack ___genetic problem

___high BP ___stoke ___ulcers ___thyroid problem ___venereal disease

___seizures ___sickle cell ___cataracts ___hypoglycemia

What is your weakest organ system and why?

____

Personal Habits

What do you enjoy most in your life? ______________________________
What are your main interests or hobbies? ______________________________
What do you worry most about in life? ______________________________
Do you exercise? (yes/no) If yes, what kind, how much and how often? ______________
Do you have a spiritual practice? (yes/no) If yes, what? ______________
On a scale of 1-10, how would you rate the quality of your sleep? (10 being great) __________
Do you have problems falling asleep__________ or problems staying asleep?__________
How many hours do you sleep at night? ______________________________
Do you awake at night? (yes/no) If yes, what time do you usually wake? ______________
Do you ever sweat at night while sleeping? (yes/no) How frequently and how much? __________
Do you wake feeling refreshed? (yes/no) Do you nap/rest horizontally during the day? (yes/no) Length____
Do you usually feel warmer or cooler compared to others around you? Hands/Feet usually cold or hot?
Do you enjoy your work? (yes/no) Do you take vacations? (yes/no)
Are you currently in a happy satisfying relationship with someone? (very, mostly, somewhat, no)
How often do you get cold's, flu's, sore throat, yeast infections during the year? ______________
When you rise quickly from sitting or lying do you ever get dizzy? (yes/no) How often? __________

Female Reproduction

Age of first menses______ If periods have stopped, at what age did they stop? _________
Are you cycles regular? (yes/no) Period begins every_____days. How many days are you periods?_______
Are your periods (heavy, medium, light) & what color is the blood? (light, dark or medium red, clots)
Do you have any spotting or bleeding between periods? (yes/no) Any cramps with period? (yes/no)
Circle any premenstrual symptoms: (water retention, breast tenderness, irritability, depression, headaches, mood swings, food cravings) other______________________________
Number of pregnancies_______ Number of abortions____________ Number of live births__________
Number of miscarriages_______________ Any problems getting pregnant? ______________
Do you get yearly PAP smears? (yes/no) Any abnormal PAP's? (yes/no) Breast lumps? (yes/no)
Are you currently sexually active? (yes/no) How often? ____________ Is this (more/less) than 1 year ago?
Do you experience vaginal dryness? (yes/no) Do you experience painful intercourse? (yes/no)
Do you use birth control? (yes/no) What type of birth control do you currently use? ______________
Have you ever been physically, sexually, emotionally or verbally abused? (yes/no) How old and how often?
____

Male Reproduction

How often do you have to get up at night to urinate? _________ Is this more than a few years ago? (yes/no)
Any problems with impotency? (getting or maintaining an erection) (yes/no) Decreased libido? (yes/no)
Any abnormal discharge from penis? (yes/no) Any venereal diseases? (yes/no) Sores on penis? (yes/no)
Any prostate problems? (yes/no & past/now) Last prostate exam? ______________ PSA? ______________
Are you currently sexually active? (yes/no) How often? ____________ Is this (more/less) than 1 year ago?
Have you ever been physically, sexually, emotionally or verbally abused? (yes/no) How old and how often?
____
____

Digestions and Elimination

Do you have any problems with gas, bloating or fullness after eating? (yes/no)
How often? (often, sometimes, never) How severe? ____________
Gas in (upper/lower abdomen or both/neither)? How long have you had this problem? ____________
Bowel movements per day? _____ Do you ever have (blood, mucus, undigested food, black stools)?
Any rectal itching? (yes/no) Do your stools tend to be (formed/loose)?
How often do you have diarrhea? _______ Do you ever have alternating constipation and diarrhea? (yes/no)
How often do you have thin, long and narrow stools? (often, sometimes, never)
How often do you have small and hard stools? (often, sometime, never)
Do you ever have yellow or light colored stools? (often, sometime, never)
How often do your stools have a strong disagreeable odor? (often, sometime, never)
Have you ever fasted? (yes/no; juice or water) For how long have you fasted? ____________
How did you feel while you were fasting? ____________
Have you traveled outside the US in the past 5 years? (yes/no) Where? ____________

Have you gone camping in the last 5 years? (yes/no) Where? ____________

Kidneys and Bladder

Have you had recurrent bladder infections? (yes/no) How were they treated? ____________
How many bladder infections have you had in the past 3 years? ____________
Do you have any burning sensation during or after urination? (past or present)
Is your urine (dark yellow, bright yellow, cloudy, pale or clear)?
Does your urine have a strong odor to it? (yes/no)
Do you have difficulty starting or stopping when urinating? (yes/no)
Do you have difficulty perspiring? (yes/no) Do you perspire when you exercise? (light, moderate, heavy)
Do you perspire other times than when exercising? (yes/no) When? ____________
Does your perspiration have a strong smell? (yes/no)

Occupational / Household / Environmental Exposures

How long have you lived at your present address? _______ What state did you previously live in? ______
Please describe current location, if old or new place, ie: new construction, damp or moldy, near power lines or industrial buildings, etc. ____________

New carpet or flooring? ____________ Recent painting or remodeling? ____________
Do you have specialized air filtration at home? (yes/no) Do you live in the city? (yes/no)
Do you work in an office building? (yes/no) Do the windows open? (yes/no)
Do you have specialized air filtration at work place? (yes/no)
Do you work in the presence of toxic fumes or chemicals? (yes/no)
Do any of your hobbies involve toxic materials? (yes/no)
Are you exposed to second hand smoke currently? (yes/no)
What do you use for your drinking water? (bottled, filtered or tap water)
As far as environmental exposures, do you have anything else you would like to comment on? ________