

# Providence Wholistic Healthcare

Integrative Natural Family Medicine & Acupuncture

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## ***Client Intake and Health History***

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: Female Male

Education \_\_\_\_\_ Email: \_\_\_\_\_

Married \_\_\_\_ Partnership \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Single \_\_\_\_

Live with: Spouse \_\_\_\_ Partner \_\_\_\_ Parents \_\_\_\_ Children \_\_\_\_ Friends \_\_\_\_ Alone \_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

Employer \_\_\_\_\_ Work phone contact \_\_\_\_\_

Work address \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

Next of Kin or other to reach in an emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

## **HEALTH HISTORY QUESTIONNAIRE**

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

**History of Health Condition(s):**

When, where & from who did you last receive medical care or general health care?

\_\_\_\_\_

\_\_\_\_\_

What was the reason? \_\_\_\_\_ Did you get blood work? \_\_\_\_\_

What kind of blood work? \_\_\_\_\_

**List your most important health problems in order of importance**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_

What is your general state of health (circle one): Excellent    Good    Average    Fair    Poor

Are you currently seeing a primary care physician? Who? What are your diagnoses?

\_\_\_\_\_

**Family History:** indicate if you or members of your close family have had the following:

	<b>Self</b>	<b>Mother</b>	<b>Father</b>	<b>Brother</b>	<b>Sister(s)</b>	<b>Grandparents (MGP) (PGP)</b>	
Cancer	_____	_____	_____	_____	_____	____/____	____/____
Diabetes	_____	_____	_____	_____	_____	____/____	____/____
Heart Disease	_____	_____	_____	_____	_____	____/____	____/____
High Blood Pressure	_____	_____	_____	_____	_____	____/____	____/____
Stroke	_____	_____	_____	_____	_____	____/____	____/____
Epilepsy	_____	_____	_____	_____	_____	____/____	____/____
Mental Illness	_____	_____	_____	_____	_____	____/____	____/____
Asthma/Allergies	_____	_____	_____	_____	_____	____/____	____/____
Anemia	_____	_____	_____	_____	_____	____/____	____/____
Kidney Disease	_____	_____	_____	_____	_____	____/____	____/____
Bowel Disease	_____	_____	_____	_____	_____	____/____	____/____
Ulcer	_____	_____	_____	_____	_____	____/____	____/____
Tuberculosis	_____	_____	_____	_____	_____	____/____	____/____
Osteoporosis	_____	_____	_____	_____	_____	____/____	____/____
Thyroid disease	_____	_____	_____	_____	_____	____/____	____/____
Age if living	_____	_____	_____	_____	_____	____/____	____/____

## Your Health History

What is your nationality/ethnicity? \_\_\_\_\_ Any known genetic risks \_\_\_\_\_

<b>Childhood Illnesses:</b>	Scarlet fever	Y N	Diphtheria	Y N	Rheumatic fever	Y N	
Mono	Y N	Mumps	Y N	Measles	Y N	German measles	Y N
<b>Immunizations:</b>	Polio	Y N	Pertussis	Y N			
Varicella	Y N	Tetanus shot	Y N	Diphtheria	Y N		
HPV	Y N	Measles/Mumps/Rubella	Y N	Other	_____		

Any history of negative reactions to vaccination? \_\_\_\_\_

### **Hospitalizations and Surgeries**

\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_

**X-Rays and Special Studies:** X-rays, CAT scans, EKGs or other studies you have had:

\_\_\_\_\_  
\_\_\_\_\_

Allergies to Medications/drugs \_\_\_\_\_

Environmental \_\_\_\_\_

Any known food sensitivities or allergies? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Current Medications:** Do you take or use...

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N
MAO inhibitors	Y N	Appetite suppressants	Y N	Diuretics	Y N

Please list **all** prescription & over-the-counter meds, vitamins & supplements you are taking?

1) \_\_\_\_\_ 4) \_\_\_\_\_  
2) \_\_\_\_\_ 5) \_\_\_\_\_  
3) \_\_\_\_\_ 6) \_\_\_\_\_  
5) \_\_\_\_\_ 7) \_\_\_\_\_

### **Typical Daily Food Intake**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages \_\_\_\_\_

Present Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs.

Weight 1 year ago \_\_\_\_\_ lbs.

Maximum Weight \_\_\_\_\_ Date \_\_\_\_\_ Desired weight \_\_\_\_\_ lbs.

**DIGESTION:**

Do you ever experience the following: Gas/bloating? Y N Frequency \_\_\_\_\_  
 Bowel movements a day? \_\_\_\_\_ Constipation? Y N Diarrhea Y N  
 Irritable bowels? Y N Bowel Disease Y N Ulcers Y N  
 Food, mucus or blood in your stool? Y N Abdominal pain? Y N  
 Frequent nausea and/or vomiting? Y N Hemorrhoids? Y N  
 Liver disease Y N Gall bladder disease Y N Heartburn Y N  
 History of oral antibiotics? Y N Average times per yr \_\_\_\_\_

**WOMEN: FEMALE REPRODUCTION/BLADDER**

Age of last menses? _____	Are cycles regular? Y N
Length of cycle? _____ days	Bleeding between cycles? Y N
Duration of menses? _____ days	Pain during intercourse? Y N
Painful menses? Y N	Clotting? Y N
Heavy or excessive flow? Y N	Discharge? Y N
PMS? Y N	Sexually active Y N
If yes, what are your symptoms? _____	Birth control? Y N Type: _____
_____	Number of pregnancies _____
_____	Number of live births _____
Endometriosis? Y N	Number of miscarriages _____
Ovarian cysts? Y N	Number of abortions _____
Difficulty conceiving? Y N	Menopausal symptoms? Y N
Cervical Dysplasia? Y N	Abnormal PAP? Y N
Sexual difficulties? Y N	Chlamydia or other STD Y N
Any difficulty with urination? Y N	Lose urine/ incontinence? Y N
Frequent urinary infections Y N	Urinary frequency Y N
Low libido Y N	Yeast infections Y N

Any history of breast (circle): Pain Lumps Fibrocystic Lumpectomy Premenstrual tenderness

Recent Mammogram Y N Family history of breast/ovarian cancer Y N \_\_\_\_\_

**MEN: PROSTATE AND URINARY HEALTH**

Do you experience difficult urination? Y N	Difficulty starting stream Y N
Painful urination Y N	Prostate disease Y N
Forked stream Y N	Testicular pain Y N
Waking at night to urinate Y N	Hernias Y N
Frequency @ night _____	Venereal disease Y N
Sexually active Y N Sexual difficulties Y N	Erectile Dysfunction Y N
Low libido Y N	

### DAILY LIFESTYLE HABITS

Which of the following do you currently use?

Tobacco, packs/day \_\_\_\_\_ Alcohol, drinks/week \_\_\_\_\_

Coffee, cups per day \_\_\_\_\_ Soda, drinks/day \_\_\_\_\_

Artificial Sweetener, per day \_\_\_\_\_ Tea, caffeinated cups per day \_\_\_\_\_

Do you exercise? Y N What form? \_\_\_\_\_ How often? \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

Average 6-8 hrs. Sleep? Y N Enjoy your work? Y N

Sleep well? Y N Take vacations? Y N

Awaken rested? Y N Spend time outside? Y N

Have a supportive relationship? Y N Watch television? Y N

Have a history of abuse? Y N how many hours? \_\_\_\_\_

Any major traumas? Y N Read? Y N

Use recreational drugs? Y N how many hours? \_\_\_\_\_

Treated for drug dependence? Y N

Do you eat three meals a day? Y N Use alcoholic beverages? Y N

Do you eat out often? Y N Treated for alcoholism? Y N

Do you go on diets often? Y N Do you use tobacco? Y N

Do you drink coffee? Y N Smoked previously? Y N

Do you drink black or green tea? Y N how many years? \_\_\_\_\_

Do you drink cola or other sodas? Y N how many packs per day? \_\_\_\_\_

Do you have a religious/spiritual practice? Y N If yes, what? \_\_\_\_\_

Main interests and hobbies: \_\_\_\_\_

How does your condition(s) affect you? \_\_\_\_\_

What do you think is happening & why? \_\_\_\_\_

What do you feel needs to happen for you to get better? \_\_\_\_\_

What do you enjoy most in your life? \_\_\_\_\_

Which of the following would you like included in your health plan if appropriate?

Dietary recommendations \_\_\_\_\_ Stress management \_\_\_\_\_ Exercise \_\_\_\_\_

Vitamins/Minerals \_\_\_\_\_ Other nutrients \_\_\_\_\_ Herbs \_\_\_\_\_ Homeopathy \_\_\_\_\_

Hydrotherapy \_\_\_\_\_ Bodywork \_\_\_\_\_ Counseling \_\_\_\_\_ Other \_\_\_\_\_

What do you think is the most important part of your healing process \_\_\_\_\_

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