

HEARTLAND NATUROPATHIC CLINIC

PATIENT PROFILE

Date _____

Name _____

Birth date _____ Age _____

Address _____

Sex _____ Height _____ Weight _____

_____ city _____ state _____ zip

Phones: Home _____ Wk/Cell _____

Email address (to be used by this office only – please print clearly)

Occupation _____ Full-time Part-time Retired

If under 18, parents' names _____

Emergency contact _____

Phone _____ Relationship _____

Family physician _____ Phone _____

Address _____

Referred by _____

YOUR SOCIAL HISTORY

Fill in and check only what applies.

- | | |
|---|--|
| <p>Marital status:</p> <input type="checkbox"/> Under 18
<input type="checkbox"/> Single
<input type="checkbox"/> Married
<input type="checkbox"/> Committed relationship
<input type="checkbox"/> Divorced
<input type="checkbox"/> Separated
<input type="checkbox"/> Widowed | <p>Living situation:</p> <input type="checkbox"/> Alone
<input type="checkbox"/> A family & children
<input type="checkbox"/> With your spouse
<input type="checkbox"/> Significant other
<input type="checkbox"/> Unrelated others
<input type="checkbox"/> With your children
<input type="checkbox"/> Full time
<input type="checkbox"/> Part time |
|---|--|

How many children have you had? _____

Education (number of years):
 HS _____ Coll _____ Voc _____ Prof _____

CURRENT HEALTH PROBLEMS: *List your most important health problems in the order of importance.*

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

YOUR PERSONAL HEALTH HISTORY: *Check the health problems you have had and relevant organ systems.*

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Reoccurring infections | <input type="checkbox"/> G.I. (digestive) disorders |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Herpes genitalis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Immune/blood system |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Musculoskeletal disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Nervous system disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Psychological problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Cardiovascular disorders | <input type="checkbox"/> Pulmonary (lung) disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Injury (serious) | <input type="checkbox"/> Endocrine (gland) disorders | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Genital/sexual disorders | <input type="checkbox"/> Urinary/kidney disorders |

Others: _____

FAMILY HEALTH HISTORY: *Check for blood relatives and state your relationship to them.*

- | | | | | |
|-------------------------------------|-----------------------------------|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizure or epilepsy | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Gout | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Venereal disease |

Others: _____

YOUR HEALTH HISTORY:

Allergies: _____

Hospitalizations, surgeries and their dates: _____

Medications currently using: _____

Supplements and natural medicines currently using: _____

FEMALE ONLY: <i>Fill in the blanks and check only what applies to you.</i>	
Painful menstruation? <input type="checkbox"/> Yes	Menopausal? <input type="checkbox"/> Yes
Excessive volume? <input type="checkbox"/> Yes	If yes, the last period was: _____
Prolonged flow? <input type="checkbox"/> Yes	Hysterectomy? <input type="checkbox"/> Yes
Premenstrual symptoms? <input type="checkbox"/> Yes	If yes: <input type="checkbox"/> Total <input type="checkbox"/> Partial When? _____
Irregular menstrual cycles? <input type="checkbox"/> Yes	_____
Length of menstrual cycles (from the first day of a period to the first day of the next period)? _____	
Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____	
Have you ever taken estrogen, progesterone or hormone replacement therapy? <input type="checkbox"/> Yes	
If yes, when, what kind and for how long? _____	
Have you used hormones for birth control, such as the birth control pill or the "shot"? <input type="checkbox"/> Yes	
If yes, when, what kind and for how long? _____	

HEALTH HABITS:

Primary interests, hobbies or activities: _____

How much and what form of regular exercise to you get? _____

If you answer YES to the following questions, please report what form, how much and how often you use them.

Do you use alcohol? Yes _____

Tobacco products? Yes _____

Recreational drugs? Yes _____

Drink coffee or soda? Yes _____

DIET: *Please describe your current typical diet.*

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What kinds of food make up your usual diet or are you on any special diets? _____

What kinds of foods do you usually avoid? _____

How much and the form of fluids you drink? _____

DISCLOSURE STATEMENT

The purpose of the natural health counseling services offered by Rachelle S. Bradley, N.D. is to help the whole person reestablish balance through removing obstacles to health and encouraging the body/mind's natural healing processes.

While Dr. Bradley is licensed as a naturopathic physician in the State of Washington, the State of Nebraska does not yet offer licensure for naturopathic physicians. Consequently, in this practice Dr. Bradley does not function as a physician, offer diagnostic services or primary care, and these services do not replace the necessary services of a licensed physician or primary care provider. You will be expected to maintain your relationship with your current primary care provider. However, Dr. Bradley is licensed in Nebraska as a mental health practitioner (LMHP) and a medical nutrition therapist (LMNT).

I, _____, as a mature adult have read
(Please print your name)

this disclosure statement and understand the limitations of these services.

I assume full responsibility for the decision to seek these services for: (check one)

Myself, or

My legal ward: _____
(Please print your child or ward's name)

Signature: _____

Date: _____