



Please fill out and return.

## Welcome to Rivergate Natural Healthcare

*Successful healthcare is possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.*

### Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Birth date \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ SS# \_\_\_\_\_

Email: \_\_\_\_\_ # of Children/names \_\_\_\_\_

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

Name of Spouse or Partner: \_\_\_\_\_ In case of emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ How did you hear about this clinic? \_\_\_\_\_

Current physicians / health practitioners \_\_\_\_\_

Date when you last received medical or health care \_\_\_\_\_

List the most important health concerns in order of their significance to you.

1) \_\_\_\_\_ Length of time: \_\_\_\_\_

2) \_\_\_\_\_ Length of time: \_\_\_\_\_

3) \_\_\_\_\_ Length of time: \_\_\_\_\_

4) \_\_\_\_\_ Length of time: \_\_\_\_\_

### General Health History

The general state of your health is: excellent \_\_\_\_\_ good \_\_\_\_\_ average \_\_\_\_\_ fair \_\_\_\_\_ poor \_\_\_\_\_

On a scale of 1-10, please rate your energy level (10 as highest) \_\_\_\_\_

What time of day is it the best? \_\_\_\_\_ the worst? \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Any change in either in the past year? Y / N

Date of last physical exam \_\_\_\_\_

**Please list significant stressful events in your life**

- 1) \_\_\_\_\_ Date: \_\_\_\_\_
- 2) \_\_\_\_\_ Date: \_\_\_\_\_
- 3) \_\_\_\_\_ Date: \_\_\_\_\_

**What surgeries, hospitalizations, X rays, MRIs, CT scans, EEGs, EKGs or other studies have you had? (please include dates)**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

**Please list any allergies or sensitivities to:**

- Medications \_\_\_\_\_
- Foods \_\_\_\_\_
- Environmental pollens / grasses \_\_\_\_\_
- Herbs / Vitamins \_\_\_\_\_
- Chemicals / Solvents \_\_\_\_\_
- Other \_\_\_\_\_

**What is your intake of the following? (please list quantity, frequency and duration)**

- Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_
- Antibiotics \_\_\_\_\_ Coffee/Tea \_\_\_\_\_
- Cortisone \_\_\_\_\_ Laxatives \_\_\_\_\_
- Sedatives \_\_\_\_\_ Antacids \_\_\_\_\_
- Pain relievers \_\_\_\_\_ Appetite suppressants \_\_\_\_\_
- Recreational drugs \_\_\_\_\_ Sleeping pills \_\_\_\_\_

**Other medications/you are currently taking (please list quantity, frequency and duration)**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Vitamins / Herbs / Supplements / Homeopathics**

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**Personal Habits**

What do you enjoy most in your life?

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What are your main hobbies or interests? \_\_\_\_\_

What do you worry most about in your life? \_\_\_\_\_

Do you exercise? Y / N If yes, what kind and how much? \_\_\_\_\_

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

Do you enjoy your work? Y / N Why or why not? \_\_\_\_\_

Do you take vacations? Y / N Do you spend time outside? Y / N

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

Are you currently in a happy, satisfying relationship with someone? *Very much* *Mostly* *Somewhat*  
*Not at all* *Not currently in a relationship*

How many hours of sleep do you get a night? \_\_\_\_\_ Do you have problems falling asleep? Y / N

Staying asleep? Y / N What time do you usually wake? \_\_\_\_\_ On a scale of 1-10, please rate  
the quality of your sleep (10 being excellent) \_\_\_\_\_ Do you ever have night sweats? Yes / No

If yes, where? \_\_\_\_\_ Do you wake feeling refreshed? Yes / No

What is your body temperature compared to others? *Warm* *Cool* *Average*

What are the temperatures of your hands and feet generally? *Warm* *Cool* *Average*

How often do you suffer from colds, flu, sore throat or infections? *Often* *Occasionally*

*Almost never*

How many hours a day do you watch TV? \_\_\_\_\_

**Food Intake**

How much of the food you eat is organic? *Very little* *Moderate* *Most* *All*

How much of the water you drink is filtered? *Very little* *Moderate* *Most* *All*

Do you eat out often? Y / N Do you drink soda? Y / N If yes, how much? \_\_\_\_\_

Please list the varieties of food you eat for each of the following:

Breakfast:	
Lunch:	
Dinner:	
Snacks:	
Beverages:	
Cravings:	Aversions:

**Childhood Illnesses**

Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella (German Measles) \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Diphtheria \_\_\_\_\_  
 Rheumatic Fever \_\_\_\_\_ Scarlet Fever \_\_\_\_\_ Mono \_\_\_\_\_ Polio \_\_\_\_\_

**Immunizations**

Measles / Mumps / Rubella \_\_\_\_\_ Diphtheria \_\_\_\_\_ Tetanus Shot \_\_\_\_\_ Polio \_\_\_\_\_ Pertussis \_\_\_\_\_  
 Other \_\_\_\_\_

**Family History**

Please check if any blood relative had any of the following:

	Father	Mother	Brothers	Sisters
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Epilepsy				
Mental Illness				
Asthma				
Hayfever				
Hives				

Kidney Disease				
Glaucoma				
Tuberculosis				
Alcoholism				
Anemia				
Depression				
Age (if living)				
Age at death				
Cause of death				

Any other relevant family history? \_\_\_\_\_  
 \_\_\_\_\_

**General Female Health History**

Do you ever do self breast exams? Y / N How often? \_\_\_\_\_

Have you ever had any problems with the following?

- |                          |       |                        |       |
|--------------------------|-------|------------------------|-------|
| Breast lumps / tumors    | Y / N | Cancer                 | Y / N |
| Nipple discharge         | Y / N | Cervical dysplasia     | Y / N |
| Vaginal discharge        | Y / N | Hysterectomy           | Y / N |
| Difficulty conceiving    | Y / N | Ovarian cysts / polyps | Y / N |
| Endometriosis            | Y / N | Bladder infections     | Y / N |
| Pain during intercourse  | Y / N | Menopausal symptoms    | Y / N |
| Chronic yeast infections | Y / N |                        |       |

Any other related issues? \_\_\_\_\_

**Menstrual History**

Age of first menses \_\_\_\_\_ If no longer having menses, what age did they stop? \_\_\_\_\_

First day of last menstrual period: \_\_\_\_\_ Menses begins every \_\_\_\_\_ days. How long does your cycle last? \_\_\_\_\_ days. The quality of your menses is: *heavy medium light* The color of the blood is *light red bright red dark red* Do you ever have any of the following PMS symptoms? *Water*

*retention Breast tenderness Irritability Depression Headaches Mood Swings Food Cravings*  
Other \_\_\_\_\_

Date of last Pap smear \_\_\_\_\_ Was it normal? Y / N

Have you ever had any problems with the following?

Irregular cycles	Y / N	Spotting between cycles	Y / N
Clots	Y / N	Cramps with menses	Y / N
Bleeding between cycles	Y / N	Pain with menses	Y / N

### **Pregnancy History**

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Number of abortions \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_ Any difficulty conceiving? Y / N Any complications during pregnancy? Y / N If yes, explain:  
\_\_\_\_\_

### **Birth Control History**

Sexual Orientation \_\_\_\_\_ Are you sexually active? Y / N If yes, how often?

\_\_\_\_\_ What type of birth control are you using? \_\_\_\_\_

What forms of birth control have you used in the past? (please include dates)  
\_\_\_\_\_

Please explain any difficulty you have had with using birth control \_\_\_\_\_

Please circle if you have ever had any of the following: *Herpes Chlamydia Gonorrhea*  
*Condyloma Syphilis Venereal Warts*

Have you used any of the following hormones?

Morning After Pill	Y / N	DES (Diethylstilbestrol)	Y / N
Estrogen	Y / N	Steroids	Y / N
Progesterone	Y / N	Cortisone	Y / N
Depo Provera	Y / N		

Other:  
\_\_\_\_\_

### **General Male Health History**

Sexual Orientation \_\_\_\_\_ Are you sexually active? Y / N If yes how often

\_\_\_\_\_ Do you use protection? Y / N If yes what type?

\_\_\_\_\_ Please circle if you have ever had any of the following: *Herpes*

*Chlamydia*      *Gonorrhea*      *Condyloma*      *Syphillis*      *Venereal Warts*      How many times do you get up at night to urinate? \_\_\_\_\_ Has this increased in recent years? Y / N

Have you ever had any problems with the following?

Inguinal Hernias	Y / N / P	Difficulty with urination	Y / N /
Penile pain	Y / N / P	P	
Erectile dysfunction	Y / N / P	Prostate problems	Y / N / P
Impotence	Y / N / P	Premature ejaculation	Y / N / P
Testicular masses?	Y / N / P	Penile discharge	Y / N / P
Testicular pain?	Y / N / P	Penile sores	Y / N / P
Testicular swelling?	Y / N / P	Pain with intercourse	Y / N / P
		Bladder infections	Y / N / P

Any other related issues? \_\_\_\_\_

### **Gastrointestinal Health**

Do you have any problems with gas, bloating, nausea or fullness after eating? Y / N      If yes, please explain (include frequency, severity, duration) \_\_\_\_\_

Do you ever feel tired after eating? Y / N      How many bowel movements do you have a day ?

\_\_\_\_\_ Please circle if you have ever had any of the following: *blood*      *mucus*      *undigested food*      *fat in stools*      *black stools*      *light stools*. Do your stools tend to be formed or loose? \_\_\_\_\_

How often do you have diarrhea? \_\_\_\_\_ Constipation? \_\_\_\_\_ Do you ever have

alternating constipation and diarrhea? Y / N      If yes how often? \_\_\_\_\_ Do your stools

frequently have a strong disagreeable odor? Y / N      Have you ever traveled outside of the US? Y / N

If yes, what countries? \_\_\_\_\_

### **Your Opinions About Your Health**

How does your condition affect you? \_\_\_\_\_

What do you think is going on for you? \_\_\_\_\_

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

What expectations do you have from this visit? \_\_\_\_\_

What long-term expectations do you have of me personally as your doctor? \_\_\_\_\_

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Please rate your present level of commitment towards improving your health

0% 0    1    2    3    4    5    6    7    8    9    10    100%

### Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are extremely happy in your career, shade the entire pie shape for career. Do the same for each area, starting from the center point radiating outwards.

