Providence Wholistic Healthcare

Sheila M. Frodermann, MS, ND, DHANP, CCH • Carol L. Seng, MAOM, DA, LAc
144 Waterman Street, Suite #3 Providence, RI 02906
www.providencewholistic.com
(401) 455-0546

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?_____ Please bring a copy for the Doctor.

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 a member of your close family have had the following

	Self	**Mother**	**Father**	**Brother**	**Sister(s)**	**Grandparents (MGP)**	**(PGP)**
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		_____	_____	_____	_____	___/__	___/__

What is your nationality/ethnicity?_____ Any known genetic risks _____

Your Health History

Childhood Illnesses: Scarlet fever Y N Diphtheria Y N Rheumatic fever Y N
Mono Y N Mumps Y N Measles Y N German measles Y N

Immunizations: 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 Y N_____

Hospitalizations and Surgeries
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

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

Allergies: Medications/drugs _____
Environmentals _____
Any 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
Stimulants	Y N	ADHD medications	Y N	Steroids	Y N

Please list **all** prescription, OTC meds, vitamins & supplements you are taking & the dose?

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4)_____ 9)_____
5)_____ 10_____

Typical Daily Food Intake

Breakfast: _____
_____
Lunch: _____
Dinner: _____
_____
Snacks_____
Beverages _____

DIGESTION

Do you ever experience the following: Gas/bloating? Y N Frequency_____
Bowel movements/day_____ Constipation? Y N Diarrhea Y N

Irritable bowel Y N Bowel Disease Y N Ulcers Y N Heartburn 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 # Antibiotics/year_____

WOMEN: FEMALE REPRODUCTION/BLADDER

Age of last menses? _____
Length of cycle? _____ days
Duration of menses? _____ days
Painful menses? Y N
Heavy or excessive flow? Y N
PMS? Y N
If yes, what are your symptoms?
_____
_____
Endometriosis? Y N
Ovarian cysts? Y N
Difficulty conceiving? Y N
Cervical Dysplasia? Y N
Sexual difficulties? Y N
Any difficulty with urination? Y N
Frequent urinary infections Y N
Low libido Y N

Are cycles regular? Y N
Bleeding between cycles? Y N
Pain during intercourse? Y N
Clotting? Y N
Discharge? Y N
Sexually active Y N
Birth control? Y N Type:_____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Menopausal symptoms? Y N
Last PAP_____Abnormal PAP Y N
Chlamydia or other STD Y N
Lose urine/ incontinence Y N
Urinary frequency Y N
Yeast infections Y N

Breast (circle): Pain Lumps Fibrocystic Lumpectomy Premenstrual tenderness Cancer
Last Mammogram:_____ Family history of breast/ovarian cancer Y N _____

MEN: PROSTATE AND URINARY HEALTH

Do you experience difficult urination Y N
Painful urination Y N
Forked stream Y N
Waking at night to urinate Y N #/night_____
Venereal disease Y N
Sexually active Y N

Difficulty starting stream Y N
Prostate disease Y N
Testicular pain Y N
Hernias Y N
Low libido Y N
Sexual difficulties Y N
Erectile Dysfunction Y N

DAILY LIFESTYLE HABITS

Do you exercise regularly? Y N What form(s) & how often? _____
_____

Present Height _____Weight _____ lbs.
Maximum Weight _____ Date_____
Weight 1 year ago _____lbs.
Desired weight _____lbs.

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

Diet and lifestyle habits continued

Average 6-8 hrs. sleep? Y N
Sleep well? Y N
Awaken rested? Y N
Have a supportive relationship? Y N
Have a history of abuse? Y N
Any major traumas? Y N
Use recreational drugs? Y N
Treated for drug dependence? Y N
Do you eat three meals a day? Y N

Enjoy your work? Y N
Take vacations? Y N
Spend time outside? Y N
Watch television? Y N
how many hours/day _____
Read? Y N
how many hours/day _____
Alcoholic drinks/ week_____
History of drinking alcohol Y N

Do you eat out often? Y N Treated for alcoholism? Y N
Do you go on diets often? Y N Use tobacco presently Y N
Coffee cups/day_____History of smoking Y N
Black or green tea cups/day_____ how many years _____
Soda/cola cups/day_____ how many packs per day_____
Any Artificial sweeteners in your diet?_____#/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 is the most important part

of your healing process? _____

_____

_____

What do you enjoy most in your life?_____

_____

_____

Are you happy? What would you do to improve your life?_____

_____

_____

Which of the following would you prefer to be included in your health plan?
Dietary recommendations_____ Stress management _____ Exercise _____
Vitamins/Minerals_____ Other nutrients_____ Herbs _____ Homeopathy_____
Hydrotherapy _____ Bodywork _____ Counseling _____ Other _____

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Client Intake and Health History – Homeopathic Addendum - Review of Systems

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 _____

Circle Y - a condition you have **P -** a condition you have had before **N -** never had this condition

Skin:

	Warts	Y P N
	Rashes	Y P N
	Eczema	Y P N
	Acne, boils	Y P N
	Itching	Y P N
	Color Change	Y P N
	Lumps	Y P N
	Night sweats	Y P N

Head:

	Headache	Y P N
	Head injury	Y P N

Eyes:

	Impaired vision	Y P N
	Glasses/contacts	Y P N
	Eye pain	Y P N
	Tearing/dryness	Y P N
	Double vision	Y P N
	Glaucoma	Y P N
	Cataracts	Y P N

Ears:

	Impaired hearing	Y P N
	Ringing	Y P N
	Earaches	Y P N
	Dizziness	Y P N

Nose/Sinuses:

	Frequent colds	Y P N
	Nose bleeds	Y P N
	Stuffiness	Y P N
	Hay fever	Y P N

Respiratory:

	Constriction	Y P N
	Cough	Y P N
	Sputum	Y P N
	Spit up blood	Y P N
	Wheezing	Y P N
	Asthma	Y P N
	Bronchitis	Y P N
	Pneumonia	Y P N
	Pleurisy	Y P N
	Difficulty breathing	Y P N
	Emphysema	Y P N
	Pain on breathing	Y P N
	Shortness of breath	Y P N
	-at night	Y P N
	-when lying down	Y P N
	Tuberculosis	Y P N

Cardiovascular:

	Heart Disease	Y P N
	Angina	Y P N
	High Blood Pressure	Y P N
	Murmurs	Y P N
	Swelling in ankles	Y P N
	Chest Pain	Y P N
	Palpitations	Y P N

Gastrointestinal:

	Liver disease	Y P N
	Heartburn	Y P N
	Ulcers	Y P N
	Change in thirst	Y P N
	Change in appetite	Y P N

Sinus problems Y P N

Mouth/Throat:

Frequent sore throat Y P N
Canker sores Y P N
Sore tongue Y P N
Gum problems Y P N
Hoarseness Y P N
Dental cavities Y P N

Neck:

Lumps Y P N
Swollen glands Y P N
Goiter Y P N
Pain or stiffness Y P N
Trouble Swallowing Y P N

Urinary:

Pain on urination Y P N
Increased frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Frequent infections Y P N
Kidney stones Y P N

Female reproductive:

Age menses began: _____
Average # of days long: _____
Total days in cycle: _____
Bleeding between Y P N
Are cycles regular Y P N
Pain during intercourse Y P N
Painful menses Y P N
Excessive flow Y P N
Birth control Y P N
Type: _____
# of pregnancies: _____
# of live births: _____
# of miscarriages: _____
# of abortions: _____
Difficulty conceiving Y P N
Menopausal symptoms Y P N
Sexually active Y P N
Venereal disease Y P N
Age Menses Ceased _____

Nausea Y P N
Vomiting Y P N
Vomit blood Y P N
Hemorrhoids Y P N
Belching/gas Y P N
Gall bladder Disease Y P N
Blood in stool Y P N
Bowel movement, how often: ___

Musculoskeletal:

Joint pain or stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasms/cramps Y P N
Weakness Y P N
Bone disease Y P N
Osteoporosis Y P N

Peripheral vascular:

Deep leg pain Y P N
Cold hands/feet Y P N
Varicose veins Y P N
Thrombophlebitis Y P N

Neurologic:

Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle weakness Y P N
Numbness/tingling Y P N
Loss of memory Y P N

Emotional:

Depression Y P N
Mood swings Y P N
Anxiety/nervousness Y P N
Tension Y P N

Endocrine:

Hypothyroid Y P N
Heat or cold intolerance Y P N
Excessive thirst Y P N
Excessive hunger Y P N

Blood problems Y P N

Easy bruising Y P N
Anemia Y P N

Breasts:

Self breast exam Y P N
Lumps Y P N
Pain or tenderness Y P N
Nipple discharge Y P N

Male reproductive:

Prostate disease Y P N
Hernias Y P N
Venereal disease Y P N
Discharge or sore Y P N
Testicular masses Y P N
Testicular pain Y P N
Sexually active Y P N
Erectile dysfunction Y P N