



natural health clinic & apothecary, inc.

16 west main street, marlton, nj 08053

609.970.2240

Confidential Health Questionnaire

Today's Date: _____

Last name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Email: _____

Evening Phone: (_____) _____ Day/CellPhone: (_____) _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

How did you hear about us?: _____

Present Health Concerns:

Please list most important health concerns in their order of significance	Prior diagnosis of problem? If so, what?
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit today?



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SYMPTOMS: Check (✓) symptoms you currently have had or have had in the past year:

General	Gastrointestinal	Eye, Ear, Nose, Throat	MEN only
<input type="checkbox"/> Chills	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Lump in testicle
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Lump in breast
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	WOMEN only
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Abnormal Pap smear
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Bleeding between period
<input type="checkbox"/> Numbness	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Breast lump/cyst
<input type="checkbox"/> Sweats	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Menstrual pain
Muscle/ Joint/ Bone	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Arms <input type="checkbox"/> Hips	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Back <input type="checkbox"/> Legs	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Painful discharge
<input type="checkbox"/> Feet <input type="checkbox"/> Neck	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Vaginal discharge/itch
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Vision-flashes/halos	Date of LMP:
Genitourinary	Cardiovascular	Skin	
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Bruise easily	
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Hives	
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Itching	
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Change in moles	
	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Rash	
	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Scars	
	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Sore that won't heal	

CONDITIONS: Check (✓) conditions you have or have had in the past:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cataracts			



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MEDICATIONS: List all prescription medications you are currently taking. Include Dosage/How often:

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History: Please list all personal medical history (i.e. hypertension, diabetes)

Family History- please list any major illnesses (cancer, stroke, etc.)				
<i>Relative</i>	<i>Age</i>	<i>State of health</i>	<i>Specific Ailment</i>	<i>If deceased, age and cause</i>
Father				
Mother				
Brother (s)				
Sister (s)				

Health Practices- Please answer the following questions.

Regular Aerobic Exercise? YES NO _____ times/week _____ duration

Smoking? YES NO _____ packs/day _____ years

Alcohol/Drug use? YES NO _____ drinks/week _____ other substance?

Caffeine? YES NO _____ daily intake



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SUPPLEMENTS: List all supplements you are currently taking.

Supplement	Dose	#Taken	How Often

ALLERGIES: List drugs that cause you an allergic reaction:

Hospitalizations and Surgeries:

Hospital Location	Date	Reason

CONSENT TO RECEIVE NATUROPATHIC SERVICES

I, _____ have been advised of my diagnosis of my current condition by a primary care provider licensed in NJ and recognize that I have the option of current medical treatment for my condition. I understand that although naturopathic physicians are licensed as primary-care physicians in many states, they are not currently licensed as such in the state of NJ. All recommendations and natural treatments suggested are not intended to diagnose a specific medical condition or replace conventional treatment as prescribed by a M.D., D.O. or other primary-care provider. All payments are due at the time of services rendered. Please give a 24-hour notice to cancel or reschedule an appointment in order to avoid a broken appointment charge.

Signature _____ Date _____