



## Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Age \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex: Male / Female Preferred Pronoun: He / She / They  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Please initial each line, indicating you understand each statement:

\_\_\_\_\_ I authorize Amy Bader, ND to examine and treat me.

\_\_\_\_\_ I understand that the treatments and therapies provided or recommended by Dr. Bader may be different from those offered by other licensed healthcare providers, and I am at liberty to seek other care as well.

\_\_\_\_\_ I have read and understand the policies of this office, including financial and cancellation policies.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

I would like to work with Dr. Bader:      In Lodi, CA      In Portland/Vancouver      On the phone

How did you hear about Dr. Bader? \_\_\_\_\_

**A note from Dr. Bader:** *Holistic and preventative healthcare is enhanced dramatically when the practitioner has a complete picture of the patient physically, mentally, emotionally and spiritually. I ask for your cooperation and patience as you complete this health history questionnaire. You may find that some of the information is difficult to recall. I only ask that you do your best. The more information you provide, the better I will be able to serve your needs. Thank you for your cooperation. I look forward to working with you.*

### HEALTH HISTORY

When, where and by whom did you last receive medical care? \_\_\_\_\_

In your opinion, what are your most important health problems? (These problems can be physical, mental and emotional.) Indicate which is/are of the most immediate concern to you.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

How do you rate your overall health?    Excellent    Good    Fair    Poor

What are your expectations for your first visit? \_\_\_\_\_

What are your expectations for our work together in general? \_\_\_\_\_

\_\_\_\_\_

**HOSPITALIZATION**

What hospitalizations or surgeries have you had? When did they occur?

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

**HEALTH STUDIES**

When was your last blood test? \_\_\_\_\_ What type of test? \_\_\_\_\_

What is your blood type? \_\_\_\_\_

Any other tests recently? \_\_\_\_\_

**MEDICATIONS**

List all drugs, vitamins, herbs being taken at present with dosage:

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

Are you allergic to any medications or other substances? Y N

If yes, please list \_\_\_\_\_

What happens when you have an "allergy attack"? \_\_\_\_\_

**CHILDHOOD ILLNESSES**

Rubella (German Measles ) \_\_\_ Measles \_\_\_ Mumps \_\_\_ Chickenpox \_\_\_ Roseola \_\_\_

Whooping cough \_\_\_ Polio \_\_\_ Rheumatic Fever \_\_\_ Scarlet Fever \_\_\_ Diphtheria \_\_\_

Frequent ear infections or colds as a child? \_\_\_\_\_ Asthma \_\_\_ Eczema \_\_\_

Any difficulties with your birth or your mother's pregnancy with you? \_\_\_\_\_

**IMMUNIZATIONS**

Polio	Y N	Pertussis	Y N
Tetanus	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other _____	

**FAMILY HISTORY**

Please list ages, any major health problems, and if deceased, what they died from and at what age.

Mother \_\_\_\_\_

Father \_\_\_\_\_

Your Sisters \_\_\_\_\_

Your Brothers \_\_\_\_\_

Mother's Side:

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

Father's Side:

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

**SOCIAL HISTORY**

Occupation \_\_\_\_\_ Work hours \_\_\_\_\_

Are you: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Single \_\_\_ Widowed \_\_\_ Partner \_\_\_

With whom do live: Spouse \_\_\_ Parents \_\_\_ Relatives \_\_\_ Friends \_\_\_ Alone \_\_\_ Other \_\_\_

Do you have the support of family and friends to make positive changes in your life? \_\_\_\_\_

Have you traveled outside the U.S? \_\_\_\_\_ Where and when? \_\_\_\_\_

Military Status: When did you serve? \_\_\_\_\_ Where? \_\_\_\_\_

Do you have a religious or spiritual practice? \_\_\_\_\_

In what areas of your life do you experience stress? Work Family Life Social Life Financial

Please list the most significant stressful events of your life (remember to include childhood):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**HEALTH HABITS**

Do you drink alcohol? \_\_\_ If so, what: Wine \_\_\_ Beer \_\_\_ Other alcohol \_\_\_\_\_

Do you use tobacco or have you in the past? \_\_\_ If so, how much? \_\_\_\_\_

Total number of years smoking? \_\_\_ Total number of years since stopped smoking? \_\_\_\_\_

Do you now or have in the past used marijuana or other drugs? \_\_\_ If yes, which drugs, how often and for how long? \_\_\_\_\_

List any longterm health problems that have resulted from taking these drugs \_\_\_\_\_

Do you exercise? \_\_\_\_\_

How often? (Hours/day and days/week) \_\_\_\_\_

Circle any of the following that you do on a regular basis:

Run Swim Walk Bicycle Garden Yoga Stretch Weights Hike Other \_\_\_\_\_

Do you make time for rest, relaxation during the day and/or before bed? \_\_\_ How often? \_\_\_\_\_

How do you relax? \_\_\_\_\_

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

**DIET**

Number of meals eaten per day: 1 2 3 more than 3

How is your appetite? \_\_\_\_\_

Where do you usually buy your food? \_\_\_\_\_ Who cooks the food you eat? \_\_\_\_\_

List the primary foods included in your diet. \_\_\_\_\_

List the foods excluded from your diet. \_\_\_\_\_

List any of the following (and relative amounts) eaten regularly by you: Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods or foods you suspect may be harmful to your health: \_\_\_\_\_

List any of the foods you crave, regardless of their nutritional value (including sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.): \_\_\_\_\_

Are you satisfied with your diet as it is now? \_\_\_ If not, why not? \_\_\_\_\_

**SLEEP**

Do you have trouble falling asleep? \_\_\_\_ If yes, what keeps you up? \_\_\_\_\_  
Do you sleep straight through the night? \_\_\_\_ If not, what time do you usually wake? \_\_\_\_\_  
Average number of hours you sleep \_\_\_\_\_ Do you wake refreshed? \_\_\_\_  
Do you have recurring dreams or nightmares? \_\_\_\_ If yes, what is the theme? \_\_\_\_\_  
What position do you usually sleep in? \_\_\_\_\_  
Is there a position you cannot sleep in? \_\_\_\_ If yes, which one? \_\_\_\_\_  
How many pillows do you sleep on? \_\_\_\_ Nights sweats? \_\_\_\_\_

**HOME ENVIRONMENT AND OTHER ENVIRONMENTAL EXPOSURES**

Circle any of the following you routinely use at home:  
Gas heat Oil heat Electric heat Wood stove Air conditioning Electric blanket T.V.  
Distilled / Filtered / Spring / Well / Tap water  
Is your home and work environment well ventilated? \_\_\_\_\_  
Is your home or work environment excessively damp or moist? \_\_\_\_\_  
Please circle any of the following you feel most bothered by:  
Sunshine Lack of sunshine Dampness Dryness Cold Heat Dust/Mold Cat/Dog hair  
Car fumes Poor air/ventilation Fluorescent lighting Chemicals Perfumes

**FEMALE REPRODUCTIVE HEALTH**

Have you ever used birth control pills? \_\_\_\_ For how long? \_\_\_\_\_ What kind? \_\_\_\_\_  
Have you ever used an I.U.D.? \_\_\_\_ For how long? \_\_\_\_\_ What kind? \_\_\_\_\_  
Hormone replacement therapy? \_\_\_\_ For how long? \_\_\_\_\_ What kind? \_\_\_\_\_  
Are you currently sexually active? \_\_\_\_ Have you been sexually active in the past? \_\_\_\_  
Current form/s of contraception \_\_\_\_\_  
Age when menstrual periods began \_\_\_\_\_ Did you have a normal puberty? \_\_\_\_\_  
Period every \_\_\_\_\_ days. Regular: Yes No  
Periods usually last \_\_\_\_\_ days (average) Date of last period \_\_\_\_\_  
Quality of blood? (i.e. dark red, bright red, clots) \_\_\_\_\_  
Amount of flow (i.e. # of pads or tampons/day) \_\_\_\_\_  
Pain or cramping? \_\_\_\_ PMS? \_\_\_\_\_  
Date of last PAP smear \_\_\_\_\_ Have you ever had an abnormal PAP? \_\_\_\_\_  
Do you currently, or have had in the past, problems with infertility \_\_\_\_ if yes, explain \_\_\_\_\_  
\_\_\_\_\_  
Number of: pregnancies \_\_\_\_ births \_\_\_\_ miscarriages \_\_\_\_ abortions \_\_\_\_  
Any complications of pregnancy? \_\_\_\_ If yes, explain \_\_\_\_\_  
Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (please circle one, 0 = none)  
Any sexual problems? \_\_\_\_\_  
Have you had any of the following concerning your breasts: Pain Lumps Infection Nipple discharge

**MALE REPRODUCTIVE HEALTH**

Are you currently sexually active? \_\_\_\_ Have you been sexually active in the past? \_\_\_\_  
Type of contraception used? \_\_\_\_\_  
Have you had any of the following: Testicular pain Prostate problems Hernia Discharges Sores  
Have you had a prostate exam? \_\_\_\_ If so, when? \_\_\_\_\_  
Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (please circle one, 0 = none)  
Any sexual problems? \_\_\_\_\_

## MEDICAL HISTORY

Please circle:

O= occasionally    Y = condition you have now    N = never had this problem    P= condition you have had in the past

### GENERAL

Weight \_\_\_\_\_  
Weight one year ago \_\_\_\_\_  
Maximum weight \_\_\_\_\_  
When? \_\_\_\_\_  
Height \_\_\_\_\_  
Last physical exam? \_\_\_\_\_

### ENERGY

Fatigue                    O    Y    N    P

### SKIN

Rashes                    O    Y    N    P  
Eczema, hives            O    Y    N    P  
Itching                    O    Y    N    P  
Color change            O    Y    N    P  
Lumps                     O    Y    N    P

### HEAD

Head aches                O    Y    N    P  
Head injury                O    Y    N    P

### EYES

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

### EARS

Impaired hearing            O    Y    N    P  
Ringing                    O    Y    N    P  
Earache                    O    Y    N    P

### NOSE and SINUSES

Frequent colds             O    Y    N    P  
Nose bleeds                O    Y    N    P  
Stuffiness                  O    Y    N    P  
Hay fever                    O    Y    N    P  
Sinus problems              O    Y    N    P

### MOUTH and THROAT

Frequent sore throat        O    Y    N    P  
Sore Tongue                O    Y    N    P  
Gum problems                O    Y    N    P  
Hoarseness                  O    Y    N    P  
Dental cavities              O    Y    N    P  
Last dental exam? \_\_\_\_\_

### RESPIRATORY

Cough                      O    Y    N    P  
Sputum                      O    Y    N    P  
Spitting up blood            O    Y    N    P  
Wheezing                    O    Y    N    P  
Asthma                      O    Y    N    P  
Bronchitis                  O    Y    N    P  
Pneumonia                  O    Y    N    P  
Pleurisy                    O    Y    N    P  
Emphysema                  O    Y    N    P  
Trouble breathing            O    Y    N    P  
Pain on breathing            O    Y    N    P  
Short of breath              O    Y    N    P  
    At night                  O    Y    N    P  
    Lying down                O    Y    N    P  
Tuberculosis                O    Y    N    P

### CARDIOVASCULAR

Heart disease              O    Y    N    P  
Angina                      O    Y    N    P  
Hypertension                O    Y    N    P  
Murmurs                    O    Y    N    P  
Rheumatic fever              O    Y    N    P  
Chest pain                  O    Y    N    P  
Swelling in ankles          O    Y    N    P  
Palpitations                 O    Y    N    P

### URINARY

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

### EXTREMITIES

Deep leg pain                O    Y    N    P  
Cold hands/feet             O    Y    N    P  
Varicose veins                O    Y    N    P  
Thrombophlebitis            O    Y    N    P  
Nail Fungus                  O    Y    N    P  
Restless legs                O    Y    N    P

### EMOTIONAL

Anxiety, panic              O    Y    N    P  
Depressed, hopeless         O    Y    N    P  
Mood swings                 O    Y    N    P  
Weeping                     O    Y    N    P  
Compulsions                 O    Y    N    P  
Excessive anger              O    Y    N    P  
Restless, bored              O    Y    N    P

### GASTROINTESTINAL

Belching/gas                O    Y    N    P  
Gall bladder                O    Y    N    P  
Heartburn                    O    Y    N    P  
Indigestion                  O    Y    N    P  
Liver problems              O    Y    N    P  
Jaundice                    O    Y    N    P  
Vomiting                    O    Y    N    P  
Vomiting blood              O    Y    N    P  
Blood in stool                O    Y    N    P  
Change in thirst             O    Y    N    P  
Change in appetite          O    Y    N    P  
Binge eating                 O    Y    N    P  
Abdominal cramps            O    Y    N    P  
Hemorrhoids                 O    Y    N    P  
Constipation                O    Y    N    P  
Diarrhea                    O    Y    N    P

### MUSCULOSKELETAL

Joint pain, stiffness        O    Y    N    P  
Arthritis                    O    Y    N    P  
Broken bones                O    Y    N    P  
Muscle spasms                O    Y    N    P  
Weakness                    O    Y    N    P

### NECK

Lumps                      O    Y    N    P  
Swollen glands              O    Y    N    P  
Goiter                        O    Y    N    P

### BLOOD

Easy bruising                O    Y    N    P  
Anemia                        O    Y    N    P

### ENDOCRINE

Hypothyroid                 O    Y    N    P  
Hyperthyroid                O    Y    N    P  
Low blood sugar              O    Y    N    P  
Diabetes                      Y    N

### NEUROLOGICAL

Fainting                    O    Y    N    P  
Seizures                    O    Y    N    P  
Paralysis                    O    Y    N    P  
Numbness/tingling          O    Y    N    P  
Memory loss                 O    Y    N    P

**WHEEL OF LIFE**

Vitality and health are a balance of many factors. Using the pie graph below, please shade your level of satisfaction in each area as it relates to you . For example: if you are extremely happy in your job, shade the entire pie shape for "Career." Do the same for each area, starting from the center point radiating outwards. ("Service" relates to giving back to the community and volunteering.)

