Dr.Chun Ming Lin,ND,R.Ph.

Holistic Family Health Consultant

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records of Dr.____

Address:____

Telephone number (   ) ___ - _______________ Fax number (   ) ___ - _______________

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to Dr.Chun Ming Lin ____________________________
____
____
all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse*:* O Yes O No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: O Yes O No

Genetic Testing O Yes O No

Please note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release____

(Name of physician, clinic name, or health organization)

employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand the there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name:____ D.O.B.___________________

Please Print

Signature: ____ Date_____________________

Please Fax to : 1-866-244-1294

Email to : drlin@usa.com

COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date:____________

First Name:________________________ Middle:____________________Last:________________

Address _________________________________ City _________________ State _____ Zip Code _____

Home Phone (____) _____-_______ Work (____) _____-_______ Cell (____) ____-_______

Email ______________________________________

Age _____ Date of Birth ____/____/_____ Place of birth________________ Gender: Female__Male___

City or town & country, if not US

Referred by:____

Name, address, & phone number of primary care physician:_______________________________

____

____

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: ____

Relationship Name Phone

____

Address

Occupation ____ Hours per week _________ Retired ______

Nature of Business____

Genetic Background: Please check appropriate box(es):

African American | Hispanic | Mediterranean | Asian
Native American | Caucasian | Northern European | Other

CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

____
____
____
____

When was the last time that you felt well?____

What seems to trigger your symptoms?____

What seems to worsen your symptoms? ____

What seems to make you feel better?____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?____
____
____

____

How much time have you lost from work or school in the past year due to these conditions? ____________

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		

Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
ILLNESS	**WHEN/ONSET**	**COMMENTS**
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
SURGERIES	**WHEN**	**COMMENTS**
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:____

____

CHILDHOOD HISTORY

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Where you a full term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				

CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: milk – diarrhea) ____
____
____
____

CHILDHOOD ILLNESSES

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	YES	AGE
ADD (Attention Deficient Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Hyperactivity		
Jaundice		

	YES	AGE
Mumps		
Pneumonia		
Seasonal allergies		
Skin disorders (e.g. dermatitis)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Other (describe)		
Other (describe)		
Measles		

As a child did you: Have a high absence from school? Yes___ No___

If yes, why? ____

Experience chronic exposure to second hand smoke in your home? Yes___ No___

Experience abuse Yes___ No___

Have alcoholic parents? Yes___ No___

FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

Pregnancies______________ Caesarean _______________ Vaginal deliveries_________

Miscarriage ______________ Abortion _________________ Living Children___________

Post partum depression___ Toxemia ________________ Gestational diabetes______

GYNECOLOGICAL HISTORY

Age at first menses?______ Frequency:________________ Length:____________________

Painful: Yes_____ No_____ Clotting: Yes____ No____

Date of last menstrual period:____/____/______

Do you currently use contraception? Yes____ No____ If yes, what please indicate which form:

Non-hormonal

Condom

Diaphragm

IUD

Partner vasectomy

Other (non-hormonal-please describe)____________________________________
____

Hormonal

Birth control pills

Patch

Nuva Ring

Other (please describe)____
____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long. ____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant. __________________________
____
____
____

Are you menopausal? Yes_____ No_____ If yes, age of menopause _______________________

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?______

Estrogen Ogen Estrace Premarin Progesterone Provera

Other _________________________________

DIAGNOSTIC TESTING

Last PAP test:_____/_____/______ Normal:___________Abnormal___________

Last Mammogram_____/_____/_____ Breast biopsy? Date:_____/_____/______

Date of last bone densitiy_____/_____/______ Results: High____ Low____ Within normal range____

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									

Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**GrandmotherMaternal**	**Maternal Grandfather**	**GrandmotherPaternal**	**Paternal Grandfather**
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson’s									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

REVIEW OF SYMPTOMS

Check (√) those items that applied to you in the ***past***. **Circle** those that ***presently*** apply

GENERAL

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Sleepwalker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted vision

SKIN:

- Cuts heal slowly
- Bruise easily
- Rashes
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness/cracking skin
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Bumps on back of arms & front of thighs
- Skin cancer
- Strong body odor

Is your skin sensitive to:

- Sun
- Fabrics
- Detergents
- Lotions/Creams

HEAD:

- Poor Concentration
- Confusion
- Headaches:
  - After Meals
  - Severe
  - Migraine
  - Frontal
  - Afternoon
  - Occipital
  - Afternoon
  - Daytime
  - Relieved by:
    - Eating Sweets
- Concussion/Whiplash
- Mental sluggishness
- Forgetfulness
- Indecisive
- Face twitch
- Poor memory
- Hair loss

EYES:

- Feeling of sand in eyes
- Double vision
- Blurred vision
- Poor night vision
- See bright flashes
- Halo around lights
- Eye pains
- Dark circles under eyes
- Strong light irritates
- Cataracts
- Floaters in eyes
- Visual hallucinations

EARS:

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss
- Itching
- Pressure
- Hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing hallucinations

NOSE/SINUSES

Stuffy
Bleeding
Running/Discharge
Watery nose
Congested
Infection
Polyps
Acute smell
Drainage
Sneezing spells
Post nasal drip
No sense of smell
Do the change of seasons tend to make your symptoms worse? Yes/No

If yes, is it worse in the:

Spring
Summer
Fall
Winter

MOUTH:

Coated tongue
Sore tongue
Teeth problems
Bleeding gums
Canker sores
TMJ
Cracked lips/ corners
Chapped lips
Fever blisters
Wear dentures
Grind teeth when sleeping
Bad breath
Dry mouth

THROAT:

Mucus
Difficulty swallowing
Frequent hoarseness
Tonsillitis
Enlarged glands
Constant clearing of throat
Throat closes up

NECK:

Stiffness
Swelling
Lumps
Neck glands swell

CIRCULATION/RESPIRATION:

Swollen ankles
Sensitive to hot
Sensitive to cold
Extremities cold or clammy
Hands/Feet go to sleep/numbness/tingling
High blood pressure
Chest pain
Pain between shoulders
Dizziness upon standing
Fainting spells
High cholesterol
High triglycerides
Wheezing
Irregular heartbeat
Palpitations
Low exercise tolerance
Frequent coughs
Breathing heavily
Frequently sighing
Shortness of breath
Night sweats
Varicose veins/spider veins
Mitral valve prolapse
Murmurs
Skipped heartbeat
Heart enlargement
Angina pain
Bronchitis/Pneumonia
Emphysema
Croup
Frequent colds
Heavy/tight chest
Prior heart attack ? When___/___/_____
Phlebitis

GASTROINTESTINAL

Peptic/Duodenal Ulcer
Poor appetite
Excessive appetite
Gallstones
Gallbladder pain

Nervous stomach
Full feeling after small meal
Indigestion
Heartburn
Acid Reflux
Hiatal Hernia
Nausea
Vomiting
Vomiting blood
Abdominal Pains/Cramps
Gas
Diarrhea
Constipation
Changes in bowels
Rectal bleeding
Tarry stools
Rectal itching
Use laxatives
Bloating
Belch frequently
Anal itching
Anal fissures
Bloody stools
Undigested food in stools

KIDNEY/URINARY TRACT:

Burning
Frequent urination
Blood in urine
Night time urination
Problem passing urine
Kidney pain
Kidney stones
Painful urination
Bladder infections
Kidney infections
Syphilis
Bedwetting
Have trichomonas

WOMEN'S HISTORY (for women only)

Fibrocystic breasts
Lumps in breast
Fibroid Tumors/Breast
Spotting
Heavy periods
Fibroid Tumors/Uterus

WOMEN'S HISTORY (for women only)

Painful periods
Change in period
Breast soreness before period
Endometriosis
Non-period bleeding
Breast soreness during period
Vaginal dryness
Vaginal discharge
Partial/total hysterectomy
Hot flashes
Mood swings
Concentration/Memory Problems
Breast cancer
Ovarian cysts
Pregnant
Infertility
Decreased libido
Heavy bleeding
Joint pains
Headaches
Weight gain
Loss of bladder control
Palpitations

MEN'S HISTORY (for men only)

Have you had a PSA done?
Yes _____ No _____
PSA Level:
0 – 2
2 – 4
4 – 10
>10

Prostate enlargement
Prostate infection
Change in libido
Impotence
Diminished/poor libido
Infertility
Lumps in testicles
Sore on penis
Genital pain
Hernia
Prostate cancer
Low sperm count
Difficulty obtaining erection
Difficulty maintaining an erection
Nocturia (urination at night)
How many times at night? ____

Urgency/Hesitancy/Change in Urinary Stream
Loss of bladder control

JOINT/MUSCLES/TENDONS

Pain wakes you
Weakness in legs and arms
Balance problems
Muscle cramping
Head injury
Muscle stiffness in morning
Damp weather bothers you

EMOTIONAL:

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts/Amnesia
- Had prior shock therapy
- Frequently keyed up and jittery
- Startled by sudden noises
- Anxiety/Feeling of panic
- Go to pieces easily
- Forgetful
- Listless/groggy
- Withdrawn feeling/Feeling 'lost'
- Had nervous breakdown
- Unable to concentrate/short attention span
- Vision changes
- Unable to reason
- Considered a nervous person by others
- Tends to worry needlessly
- Unusual tension

EMOTIONAL (CONTINUED)

- Frustration
- Emotional numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Previously admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Misunderstood by others
- Irritable/
- Feeling of hostility/volatile or aggressive
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

PAIN ASSESSMENT

Are you currently in pain? Yes ___ No___

Is the source of your pain due to an injury? Yes___ No___

If yes, please describe your injury and the date in which it occurred:______________________

____

If no, please describe how long you have experienced this pain and what you believe it is attributed to:____

Please use the area(s) and illustration below to describe the severity of your pain.
(0= no pain, 10= severe pain)

Example:______Neck______________
0 1 2 3 4 5 (6) 7 8 9 10

Area 1.______________________
1 2 3 4 5 6 7 8 9 10

Area 2.______________________
1 2 3 4 5 6 7 8 9 10

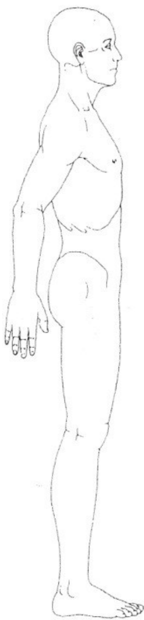
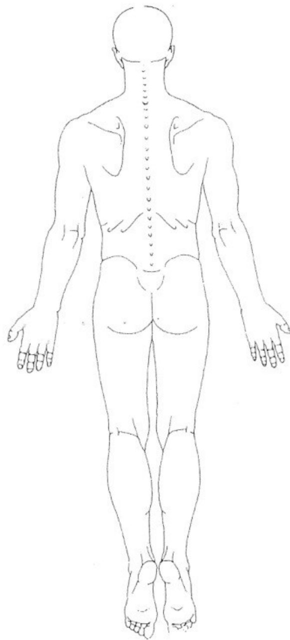
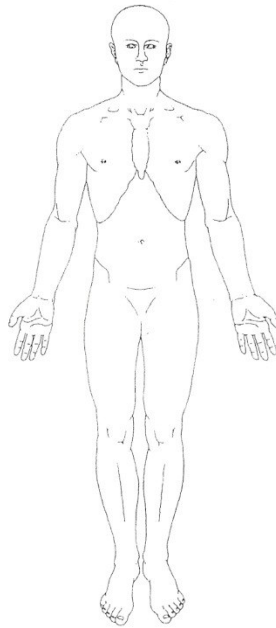
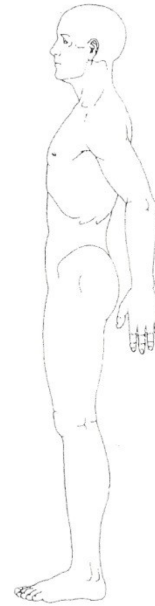
Area 3.______________________
1 2 3 4 5 6 7 8 9 10

Area 4.______________________
1 2 3 4 5 6 7 8 9 10

Use the letters provided to mark your area(s) of pain on the illustration.

Right Side Back Front Left Side

Z=sharp/shooting

Right Side Back Front Left side

DENTAL HISTORY

	Yes	No
Problem with sore gums (gingivitis)?	______	______
Ringing in the ears (tinnitus)?	______	______
Have TMJ (temporal mandibular joint) problems?	______	______
Metallic taste in mouth?	______	______
Problems with bad breath (halitosis) or white tongue (thrush)?	______	______
Previously or currently wear braces?	______	______
Problems chewing?	______	______
Floss regularly?	______	______
Do you have amalgam dental fillings? How many?	______	______
Did you receive these fillings as a child?	______	______

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
None	None	None
Bacon/Sausage	Butter	Beans (legumes)
Bagel	Coffee	Brown rice
Butter	Eat in a cafeteria	Butter
Cereal	Eat in restaurant	Carrots
Coffee	Fish sandwich	Coffee
Donut	Fried foods	Fish
Eggs	Hamburger	Green vegetables
Fruit	Hot dogs	Juice
Juice	Juice	Margarine
Margarine	Leftovers	Milk
Milk	Lettuce	Pasta
Oat bran	Margarine	Potato
Sugar	Mayo	Poultry
Sweet roll	Meat sandwich	Red meat
Sweetener	Milk	Rice
Tea	Pizza	Salad
Toast	Potato chips	Salad dressing
Water	Salad	Soda
Wheat bran	Salad dressing	Sugar
Yogurt	Soda	Sweetener
Oat meal	Soup	Tea
Milk protein shake	Sugar	Vinegar
Slim fast	Sweetener	Water
Carnation shake	Tea	White rice
Soy protein	Tomato	Yellow vegetables
Whey protein	Vegetables	Other: (List below)
Rice protein	Water	
Other: (List below)	Yogurt	
	Slim fast	
	Carnation shake	
	Protein shake	

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? Yes____ No_____

Ovo-lacto
Diabetic
Dairy restricted
Vegetarian
Vegan
Blood type diet
Other (describe)____

Please tell us if there is anything special about your diet that we should know. ________________
____

Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc?
Yes___ No____
If yes, are these symptoms associated with any particular food or supplement?
Yes___ No____
If yes, please name the food or supplement and symptom(s). ____________________________
____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

High fat foods
High protein foods
High carbohydrate foods (breads, pasta, potatoes)
Refined sugar (junk food)
Fried foods
1 or 2 alcoholic drinks
Other_________________________

Do you feel **better** when you eat a lot of:

High fat foods
High protein foods
High carbohydrate foods (breads, pasta, potatoes)
Refined sugar (junk food)
Fried foods
1 or 2 alcoholic drinks
Other_________________________

Does skipping meals greatly affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or ‘binged’ on over a period of time?

Yes _____ No _____ If yes, what food(s) ____

____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) ____

____

Please complete the following chart as it relates to your bowel movements:

Frequency	√	Color	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

Intestinal gas:

Daily

Occasionally

Excessive

Present with pain

Foul smelling

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much?______________________________

Number of years?____________If not a current user, year quit________________

Attempts to quit: __________

Are you exposed to 2nd hand smoke regularly? If yes, please explain:______________________________

____

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

No longer drink alcohol

Average 1-3 drinks per week

Average 4-6 drinks per week

Average 7-10 drinks per week

Average >10 drinks per week

Do you notice a tolerance to alcohol (can you “hold” more than others?) Yes____ No____

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From__________ to __________

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____

If yes, what type(s) and method? (IV, inhaled, smoked, etc)____________________________________

____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___No___

If yes, indicate which

Lead

Arsenic

Aluminum

Cadmium

Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

Have trouble falling asleep? Use sleeping aids?

Feel rested upon wakening?

Have problems with insomnia?

Snore?

EXERCISE HISTORY

Do you exercise regularly? Yes____ No____

If yes, please indicate:

Type of exercise	Times/week				Length of session			
	1x	2x	3x	4x/+	≤15 min	16-30 min	31-45 min	>45 min
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be? ______________________________________

Have you ever contemplated suicide? Yes____ No____

If yes, how often? ______ When was the last time?_____

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc) ________________________________

Did it help?___________

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

Spouse Family Friends Religious/Spiritual Pets Other _____________

Have you ever been involved in abusive relationships in your life? Yes ___ No___
Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___
Did you feel safe growing up? Yes ___ No___
Was alcoholism or substance abuse present in your childhood home? Yes ___ No___
Is alcoholism or substance abuse present in your relationships now? Yes ___ No___
How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___
If yes, how often? _______________
Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other

Hobbies and leisure activities:
____
____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes_____ No_____

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Take nutritional supplements each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Keep a record of everything you eat each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Modify your lifestyle (e.g. work demands, sleep habits)	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Practice relaxation techniques	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Engage in regular exercise	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Have periodic lab tests to assess progress	5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments ____

____

Statement of Consent

I ___________________________ understand the treatment modalities that my naturopathic doctor may use with me. I understand potential risks and side effects of naturopathic treatment and that my naturopathic doctor cannot anticipate and explain all risks and complications that may arise. I understand that naturopathic medicine, like all medicine, cannot guarantee results. I further understand that advice and/or treatments offered to me by my naturopathic doctor are not intended to substitute for or replace advice and/or treatment provided to me by my medical doctor.

With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures outlined above except for (please list exceptions, if any).

____

____

____

This consent form is intended to apply to the entire course of my care by my naturopathic doctor (and/or naturopathic doctor substituting for her/him). I understand that at any time I may (in writing) withdraw consent to any further treatment and discontinue treatment at any time.

Signature of patient/Guardian _____________________________________

Date ___________________________________

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and well being.

Sincerely,

Dr.Chun Ming Lin,ND,RPh.