

# HEARTLAND NATUROPATHIC CLINIC

## PATIENT PROFILE

Date \_\_\_\_\_

Name \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

\_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip

Phones: Home \_\_\_\_\_ Wk/Cell \_\_\_\_\_

Email address (to be used by this office only – please print clearly)  
\_\_\_\_\_

Occupation \_\_\_\_\_  Full-time  Part-time  Retired

If under 18, parents' names \_\_\_\_\_

Emergency contact \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Referred by \_\_\_\_\_

### YOUR SOCIAL HISTORY

*Fill in and check only what applies.*

- |   |  |
|---|--|
| <p>Marital status:</p> <input type="checkbox"/> Under 18<br><input type="checkbox"/> Single<br><input type="checkbox"/> Married<br><input type="checkbox"/> Committed relationship<br><input type="checkbox"/> Divorced<br><input type="checkbox"/> Separated<br><input type="checkbox"/> Widowed | <p>Living situation:</p> <input type="checkbox"/> Alone<br><input type="checkbox"/> A family & children<br><input type="checkbox"/> With your spouse<br><input type="checkbox"/> Significant other<br><input type="checkbox"/> Unrelated others<br><input type="checkbox"/> With your children<br><input type="checkbox"/> Full time<br><input type="checkbox"/> Part time |
|---|--|

How many children have you had? \_\_\_\_\_

Education (number of years):  
 HS \_\_\_\_\_ Coll \_\_\_\_\_ Voc \_\_\_\_\_ Prof \_\_\_\_\_

### CURRENT HEALTH PROBLEMS: *List your most important health problems in the order of importance.*

- |          |          |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

### YOUR PERSONAL HEALTH HISTORY: *Check the health problems you have had and relevant organ systems.*

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Hepatitis A/B/C     | <input type="checkbox"/> Reoccurring infections      | <input type="checkbox"/> G.I. (digestive) disorders |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Herpes genitalis    | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Immune/blood system        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Musculoskeletal disorders  |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Nervous system disorders   |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Venereal disease            | <input type="checkbox"/> Psychological problems     |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Cardiovascular disorders    | <input type="checkbox"/> Pulmonary (lung) disorders |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Injury (serious)    | <input type="checkbox"/> Endocrine (gland) disorders | <input type="checkbox"/> Skin disorders             |
| <input type="checkbox"/> Gout               | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Genital/sexual disorders    | <input type="checkbox"/> Urinary/kidney disorders   |

Others: \_\_\_\_\_

### FAMILY HEALTH HISTORY: *Check for blood relatives and state your relationship to them.*

- |                                     |                                   |  |  |   |
|-------------------------------------|-----------------------------------|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Hay fever           | <input type="checkbox"/> Mental illness      | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia     | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Seizure or epilepsy | <input type="checkbox"/> Thyroid disease  |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sickle cell anemia  | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Gout     | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Skin disorders      | <input type="checkbox"/> Venereal disease |

Others: \_\_\_\_\_

**YOUR HEALTH HISTORY:**

Allergies: \_\_\_\_\_

Hospitalizations, surgeries and their dates: \_\_\_\_\_

Medications currently using: \_\_\_\_\_

Supplements and natural medicines currently using: \_\_\_\_\_

<b>FEMALE ONLY:</b> <i>Fill in the blanks and check only what applies to you.</i>	
Painful menstruation? <input type="checkbox"/> Yes	Menopausal? <input type="checkbox"/> Yes
Excessive volume? <input type="checkbox"/> Yes	If yes, the last period was: _____
Prolonged flow? <input type="checkbox"/> Yes	Hysterectomy? <input type="checkbox"/> Yes
Premenstrual symptoms? <input type="checkbox"/> Yes	If yes: <input type="checkbox"/> Total <input type="checkbox"/> Partial When? _____
Irregular menstrual cycles? <input type="checkbox"/> Yes	_____
Length of menstrual cycles (from the first day of a period to the first day of the next period)? _____	
Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____	
Have you ever taken estrogen, progesterone or hormone replacement therapy? <input type="checkbox"/> Yes	
If yes, when, what kind and for how long? _____	
Have you used hormones for birth control, such as the birth control pill or the "shot"? <input type="checkbox"/> Yes	
If yes, when, what kind and for how long? _____	

**HEALTH HABITS:**

Primary interests, hobbies or activities: \_\_\_\_\_

How much and what form of regular exercise to you get? \_\_\_\_\_

*If you answer YES to the following questions, please report what form, how much and how often you use them.*

Do you use alcohol?  Yes \_\_\_\_\_

Tobacco products?  Yes \_\_\_\_\_

Recreational drugs?  Yes \_\_\_\_\_

Drink coffee or soda?  Yes \_\_\_\_\_

**DIET:** *Please describe your current typical diet.*

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

What kinds of food make up your usual diet or are you on any special diets? \_\_\_\_\_

What kinds of foods do you usually avoid? \_\_\_\_\_

How much and the form of fluids you drink? \_\_\_\_\_

### DISCLOSURE STATEMENT

The purpose of the natural health counseling services offered by Randall S. Bradley, N.D. is to help the whole person reestablish balance through removing obstacles to health and encouraging the body/mind's natural healing processes.

While Dr. Bradley is licensed as a naturopathic physician in the State of Washington, the State of Nebraska does not yet offer licensure for naturopathic physicians. Consequently, in this practice he does not function as a physician or offer diagnostic services, and his services do not replace the necessary services of a licensed physician. However, Dr. Bradley is licensed in Nebraska as a mental health practitioner (LMHP) and a medical nutrition therapist (LMNT).

I, \_\_\_\_\_, as a mature adult have read  
(Please print your name)

this disclosure statement and understand the limitations of these services.

I assume full responsibility for the decision to seek these services for: (check one)

Myself, or

My legal ward: \_\_\_\_\_  
(Please print your child or ward's name)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_