Health Profile

Patient Name: ____________________________________ Today's Date:________________

Reason(s) for today's visit:

What are three expectations you have of today's visit?

1. ____
2. ____
3. ____

What are your long-term expectations / goals?

1. ____
2. ____
3. ____

What do you know about the Naturopathic approach to health care?

What are your expectations of me as your Naturopathic Doctor?

What is your current state of health on a scale of 1 to 10 (poor to optimal)?

1 2 3 4 5 6 7 8 9 10

What is your dedication to improving your health on a scale of 1 to 10 (minimal to total)?

To Find the Cause: 1 2 3 4 5 6 7 8 9 10

To Make a Change: 1 2 3 4 5 6 7 8 9 10

What lifestyle habits/behaviors of yours are currently helpful for your health?

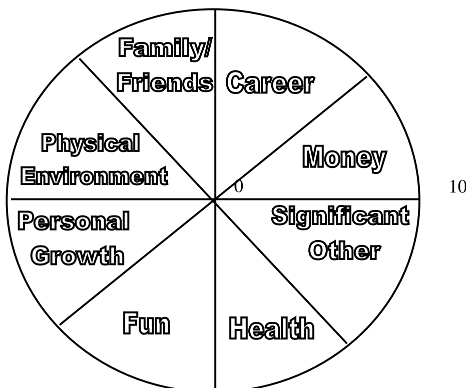
What lifestyle habits/behaviors of yours are currently destructive towards your health?

What do you perceive as obstacles to your participation in a comprehensive naturopathic health program?

Who do you know who will consistently support your process in this journey?

Please describe what relationship between your current health status and of your lifestyle?

Wheel of Balance: Please rate each section of the wheel from 0 to 10 (0 = none (center), 10 = complete (outer edge) based on how satisfied you are with the state of affairs for that section. You may draw a tic mark on each axis that corresponds to the category and then connect the marks. For example if you are only half satisfied with your career, place a tick mark half way along the axis to the right of 'Career' to represent a score of five.



Lifestyle

I. Diet

Do you follow a special diet? Yes No If yes, please describe:

How many meals do you eat per day? _________

How many glasses of water do you drink per day? _________

Describe a typical breakfast:

____

Describe a typical lunch:

____

Describe a typical dinner:

____

Describe typical snacks:

____

How many times a week do you eat out? ____________

What percentage of your food is organic? ____________

How frequently do you do the following? (Never - N, Occasionally - O, Weekly - W, Daily - D)

- Eat red meat?
- Eat poultry / fish?
- Eat dairy? (cheese, milk)
- Eat fresh vegetables?
- Eat fresh fruits?
- Eat whole grains?
- Eat nuts / seeds?
- Eat sweets / chocolate / sugar?
- Drink coffee / black tea / beverages containing caffeine?
- Drink alcohol (please describe)?
- Use nicotine (please describe)?
- Use recreational drugs (please describe)?
- Have a bowel movement?
- Do aerobic exercise (please describe)?
- Do strength training exercise?
- Do stretching or yoga?

II. Sleep

What is your average # of hours of sleep per night? __________

Do you have trouble falling asleep? Rarely Sometimes Frequently

Do you awaken frequently at night? Rarely Sometimes Frequently

If yes, how long does it take to fall back to sleep? _____________

Do you wake up feeling refreshed? Rarely Sometimes Frequently

Do you snore? Yes No

Do you experience sleep apnea? Yes No

III. Stressors and Stress Level

Do you frequently feel short of time?

Do you feel frustrated by your present circumstances (personal, relationship, work)?

Please describe your main stressor(s) in life:

How do you cope with your stresses in life?

Do you have a religious/spiritual orientation/practice that is important to you?

Relationship Status:

Single Married - (How long)? ____Divorced (When?) _______Widowed (When?)_________

Are you pregnant currently? Yes No

Have you been pregnant? Yes No How many live births? ____

Please list the name(s), gender and ages of your children, if any: