



WHITE MOUNTAIN CLINIC

PATIENT INFORMATION *please print*

This patient history form is extensive, but so very important. Please give yourself adequate time for completion.

Patient's Name: _____
First Middle Last

Address: _____

City, State, Zip code: _____

Telephone, daytime: _____ Telephone, evening: _____

May we leave messages for you at these numbers? Yes No

Date of Birth: _____ Age: _____ Male Female

SSN: _____

Mother's Name: _____ Date of Birth: _____

Occupation: _____

Father's Name: _____ Date of Birth: _____

Occupation: _____

Parents are: Married Divorced Separated Single

Siblings:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Who lives at home with the patient? _____

Patient's School: _____

Most recent primary care information:

Physician's Name: _____

Address: _____

City, State, Zip code: _____

Emergency Contact: _____

Relationship: _____ Telephone: _____

How did you hear about us? _____

Signature: _____ Date: _____

Holistic Health care

Naturopathic Medicine

Classical Chinese Medicine

Prevention

Treat the Whole Person

Treat the Cause

Education

Healing Power of Nature

Do No Harm

WHITE MOUNTAIN CLINIC

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PATIENT HEALTH HISTORY QUESTIONNAIRE

What is your most important health concern? _____

How long have you had this particular concern or condition? _____

What do you believe is the cause? _____

If you were treated (home care or by doctor), what method or medicine was used? and what was the result? _____

Please check (✓) the box if this condition

- | | |
|--|--|
| <input type="checkbox"/> is getting worse | <input type="checkbox"/> interferes with work or school |
| <input type="checkbox"/> is constant | <input type="checkbox"/> interferes with sleep |
| <input type="checkbox"/> is worse in the morning | <input type="checkbox"/> interferes with movement and /or exercise |
| <input type="checkbox"/> is worse in the afternoon | <input type="checkbox"/> you have had this or similar conditions in the past |
| <input type="checkbox"/> is worse in the evening | <input type="checkbox"/> notice it more during _____ |

Please list additional health concerns: _____

When was your last visit to a doctor's office, medical clinic, or hospital? What was the reason? _____

Are you under the care of a medical specialist? If yes, please explain. _____

Are you currently under the care of or have you been treated in the past by a naturopathic physician, homeopath, or Chinese medicine practitioner? If yes, please give names of providers and dates of treatment. _____

What are your goals and expectations from our clinic? _____

Please list medications, vitamins and supplements that you currently take; prescription and over the counter.

Have you ever had any known adverse reactions to medications or medical procedures? If yes, please explain.

Do you have allergies to foods, drugs or other allergens in your environment (e.g. cats, mold, dust)?

What hospitalizations or surgery have you had? Please give dates and reasons.

Have you ever had a blood transfusion? Yes No Was it your blood taken previously, or a donor's blood?
(circle one)

What diagnostic imaging studies have you had?

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Bone Density Scan (DXA) | <input type="checkbox"/> Electroencephalogram (EEG) | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Colonoscopy/ Sigmoidoscopy | <input type="checkbox"/> Echocardiogram (Echo) | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> X-ray |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Mammogram | |
| <input type="checkbox"/> Electrocardiogram (ECG/EKG) | <input type="checkbox"/> Other _____ | |

What immunizations have you had? Include international travel vaccinations if applicable.

- | | | |
|---|---|---|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Measles, Mumps, Rubella (MMR) |
| <input type="checkbox"/> Diphtheria, Tetanus | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polio; <input type="checkbox"/> inactive (IPV) <input type="checkbox"/> oral (OPV) |
| <input type="checkbox"/> Diphtheria, Tetanus, Pertussis | <input type="checkbox"/> Influenza (Flu shot) | <input type="checkbox"/> Rubella, single |
| <input type="checkbox"/> Tetanus, single | <input type="checkbox"/> Measles, single | <input type="checkbox"/> Varicella (Chicken Pox) |
| <input type="checkbox"/> Haemophilus Influenza type b | <input type="checkbox"/> Mumps, single | <input type="checkbox"/> Other _____ |

Are your immunizations current? Yes No

If not, please explain:

Medical exemption

Religious exemption

Philosophical exemption

Other _____

Have you had the following illnesses? Leave blank if unsure.

Diphtheria Yes No

Rheumatic Fever Yes No

German Measles Yes No

Scarlet Fever Yes No

Measles Yes No

Strep Throat Yes No

Mumps Yes No

Other _____

GENERAL REVIEW

Weight, current: _____

Weight, 1 year ago: _____

Maximum weight: _____

when _____

Height: _____

Breast fed as an infant? Yes No

for how long? _____

Do you sleep well? Yes No

Wake feeling rested? Yes No

How many hours of sleep? _____

Eat three meals daily? Yes No

Enjoy school? Yes No

Spend time outside? Yes No

Watch television? Yes No

hours per day -or- per week? _____
(circle one)

What type of exercise do you do? how often?

What are your main interests and hobbies?

BIRTH HISTORY

Any problems during the pregnancy? Yes No

Please describe: _____

Was mom on any medications during the pregnancy?

Yes No

Please describe: _____

Cigarettes/ alcohol/ drugs used during the pregnancy?

Yes No

Please describe: _____

Patient born On time Late Early/Premature

Patient delivered Vaginal C-section

Forceps Suction

Patient's birth weight: _____

Any complications during delivery? Yes No

Please describe: _____

DEVELOPMENTAL / SCHOOL CONCERNS

Has your child ever had any concerns regarding:

Slow development (sitting, walking, talking)

Yes No

Speech (late talker, hard to understand) Yes No

School difficulties (learning, attention) Yes No

Other concerns: _____

Date of last physical exam? _____

Date of last dental exam? _____

Any abnormal findings? Yes No

If yes, please explain: _____

FOOD & DIET

Please describe your typical food intake.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Favorite foods: _____

How many glasses of plain water do you drink per day: _____ Is it filtered? Yes No

How many cans of soda do you drink per day: _____ What type? _____

How many glasses of fruit juice do you drink per day: _____ What type? _____

Do you consider yourself a picky or adventurous eater?
(circle one)

Which flavors do you like?

Sweet Salty Bitter Sour Aromatic Spicy Bland

Do you follow a certain type of diet? Yes No

Please explain: _____

Please check (✓) the box for any of the following that you or your family members have experienced.

Alcoholism	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Allergies	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Bleeding Disorders	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Blood Clots	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Sickle cell Anemia	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Arthritis	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Asthma/ Wheezing	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Cancer	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Type:	<hr/>						
Depression	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Diabetes	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Drug Addiction	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Eczema	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Epilepsy/ Seizures	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Gastrointestinal Disorder	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Gum Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Hay Fever / Hives	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Heart Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Heart Murmur	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
High blood pressure	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
High cholesterol	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Inherited/ Genetic Disorder	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Type:	<hr/>						
Kidney Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Liver Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Lung Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Mental Illness	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Musculoskeletal Disorder	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Neurological Disorder	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Sudden Death	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Stroke	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Thyroid Condition	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Tuberculosis	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Ulcer	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Urinary Disorder	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent
Vascular Disorder	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> child	<input type="checkbox"/> grandparent

PARENT'S HEALTH

Father

Health: Good Average Poor

Age, if living _____

Age, when deceased _____

Mother

Health: Good Average Poor

Age, if living _____

Age, when deceased _____

REVIEW OF SYSTEMS

Please check (✓) the box for any conditions your child has experienced.

Blood / Peripheral Vascular

- Anemia
- Cold hands / feet
- Easy bleeding / bruising

Cardiovascular

- Chest pain
- Fainting / Light-headed
- Heart Disease
- Heart beat, irregular
- Heart Murmur
- Palpitations, fluttering
- Rheumatic fever

Ears

- Dizziness / Vertigo
- Earache
- Ear infections
- Ear tubes
- Ears, itchy
- Hearing, impaired
- Ringing, tinnitus
- Wax, excessive

Endocrine

- Fatigue
- Heat or cold intolerance
- Hyperglycemia
- Hypothyroid
- Thirst changes

Eyes

- Blurriness
- Color blindness
- Dryness, excessive
- Itchy eyes
- Eye pain
- Glasses or contacts
- Tearing, excessive
- Vision problems

Mouth and Throat

- Bad breath
- Dental cavities/ fillings
- Frequent sore throat
- Frequently clear throat
- Gum problems
- Hoarseness
- Metallic taste in mouth
- Mouth sores
- Saliva, excess
- Sore tongue, lips
- Teeth grinding

Gastrointestinal

- Abdominal Pain, cramps
- Alt. diarrhea/ constipation
- Belching
- Blood in stool
- Bowel movements, how often? ____/day -or- ____/wk
- Bulimia
- Appetite / feeding concerns
- Constipation
- Diarrhea
- Fatigue after eating
- Flatulence / Gas
- Hepatitis
- Hernia, repaired
- Jaundice (yellow skin)
- Liver disease
- Painful stool
- Parasites, diagnosed
- Stomach pain
- Trouble swallowing
- Vomiting

Head

- Headache
- Head Injury
- Jaw, TMJ problems

Neck

- Goiter
- Lumps
- Pain or stiffness
- Whiplash history

Immune System

- Chicken Pox, year _____
- Fatigue
- Frequent colds
- Infections, chronic
- Slow wound healing
- Swollen glands
- Tonsils/ Adenoids Removal
- Vaccine Reactions

Mental / Emotional

- Anxiety, nervousness
- Depression
- Concentration, difficult
- Mood swings
- Hyperactivity
- Treatment for mental/ emotional concerns

Musculoskeletal

- Arch supports / heel lifts
- Arthritis, Rheumatoid
- Broken Bones
- Joint pain or stiffness
- Joint swelling
- Muscle Pain
- Muscle spasms / cramps
- Muscle weakness, tiredness
- Sports Injuries

Neurologic

- Loss of Memory
- Numbness or tingling
- Paralysis
- Febrile Seizures
- Other Seizures
- Tremor

Nose and Sinuses

- Hay fever
- Nose bleeds
- Red nose
- Runny nose
- Sinus problems
- Stuffiness, congestion

Respiratory

- Asthma
- Bronchitis
- Cough
- Difficulty breathing
- Pain on breathing
- Pneumonia
- Spitting up blood
- Wheezing

Skin

- Acne
- Boils
- Cancer
- Color change
- Eczema
- Hives
- Itching
- Lumps
- Moles
- Rashes

Urinary

- Bed wetting
- Frequent infections
- Frequency at night
- Urinary Tract Infection

SOCIAL / SAFETY HISTORY

Is there any old peeling paint inside/ outside the home? Yes No

Is there a working smoke alarm on each floor? Yes No

Are there any guns in your house? Yes No

If so, are all firearms securely locked up? Yes No

Is your child always buckled into a securely fastened car seat or seat belt while riding in the car? Yes No

Do all other family members buckle up? Yes No

Does your child wear a helmet when bike riding, roller blading, or skateboarding? Yes No

Are there any smokers in the household or childcare setting? Yes No

Please check (✓) any stresses in your household or environment:

- Job difficulties
- Money worries
- Separation / Divorce
- Domestic Violence
- Mental Illness
- Drug / alcohol abuse
- Incarceration
- Other: _____

If you would like to provide us with any additional information about yourself, please do so here:

*All information will be kept confidential in your medical records
and will not be released without your permission.*

Thank you for your time and consideration.