Seattle Naturopathic Clinic Date_____

Rebecka Hoppins Campbell, ND

New Client Profile

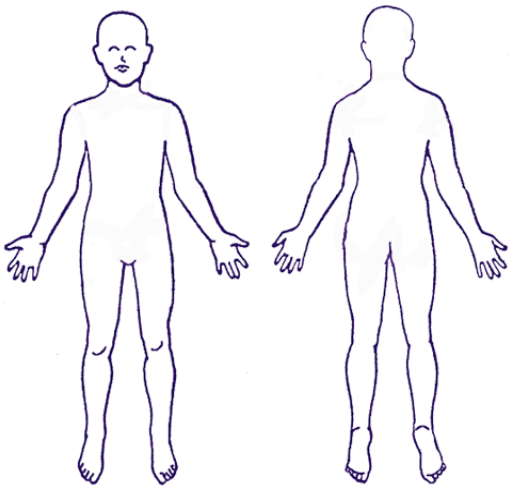
Name: _____

Last First M.I.

Nickname (if preferred)_____Birthdate:_____/_____/_____

Female_____ Male_____ Drug Allergies_____

Current Health Concerns: Please list your most important health concerns in order of significance to you.

1.	Please indicate area of problem(s): 
2.	
3.	
4.	
5.	
6.	

Current diagnoses:

1.
2.
3.
4.
5.

Current prescription meds w/ dosages:

1.
2.
3.
4.
5.

Please list all supplements you are **currently** taking including herbs, vitamins, minerals, homeopathic remedies, with dosages:

1.	4.
2.	5.
3.	6.

(Please see other side)

Please circle any of the following that you use regularly, include amount and how often:
Coffee/black tea/cola_____ /day/wk/mo Alcohol _____/day /wk /mo
Recreational drugs_____/day /wk /mo Tobacco_____/day /wk /mo

Do you follow any particular diet regimens or restrictions? ____ Please describe:_____
_____

Diet:	Never	Occasionally	#/Week	#/day
Meat	_____	_____	_____	_____
Fish	_____	_____	_____	_____
Fresh Veggies	_____	_____	_____	_____
Fresh Fruit	_____	_____	_____	_____
Dairy	_____	_____	_____	_____
Whole grains	_____	_____	_____	_____
Sweets	_____	_____	_____	_____

Water intake:
oz/day_____
Hours of sleep per night?
_____
Wake refreshed? Y N
Wake during the night? Y N
Describe:_____
_____

Do you exercise regularly? Yes No What type(s)?_____
How often?_____ How long?_____

Family Medical History:
Please check "yes" to each condition that applies to one of your family members, include grandparents, blood-related aunts and uncles where possible.

	Yes	No	Relation (deceased?)		Yes	No	Relation (deceased?)
Alcoholism Drug/addiction				Epilepsy			
Allergies				Headaches			
Anemia				Heart Disease			
Arthritis				Hepatitis			
Asthma				High blood pressure			
Autoimmune disorder				Mental illness (type)			
Cancer (please indicate type)				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			

(please circle) Married Single Significant Other

Do you have children? Yes No Ages_____

(Please see next page)

Name_____

Past Medical History:
Date of last physical exam_____ Date of last blood tests_____

Personal History
Illnesses: Have you ever had-
Measles.....No Yes Current
German Measles.....No Yes Current
(Rubella)
Mumps .....No Yes Current
Chicken pox .....No Yes Current
Whooping Cough .....No Yes Current
(Croup)
Scarlet Fever .....No Yes Current
Diphtheria .....No Yes Current
Smallpox .....No Yes Current
Pneumonia .....No Yes Current
Influenza .....No Yes Current
Pleurisy .....No Yes Current
Rheumatic Fever .....No Yes Current
Heart Disease .....No Yes Current
Arthritis/Rheumatism .....No Yes Current
Bone or Joint Disease .....No Yes Current
Neuralgia .....No Yes Current
Sciatica.....No Yes Current
Bursitis, Lumbago .....No Yes Current
Polio .....No Yes Current
Meningitis .....No Yes Current
Nephritis .....No Yes Current
Gonorrhea, ...No Yes Current
Chlamydia .....No Yes Current
Syphilis .....No Yes Current
Herpes .....No Yes Current
Gallbladder disease .....No Yes Current
Anemia (Type) .....No Yes Current
Jaundice .....No Yes Current
Hepatitis .....No Yes Current
Urinary bladder disease .....No Yes Current
Seizures..... No Yes Current
Migraine Headaches.....No Yes Current
Tuberculosis .....No Yes Current
Diabetes (type).....No Yes Current
Cancer (type) .....No Yes Current
High blood pressure .....No Yes Current
Low blood pressure.....No Yes Current
Colitis/bowel disease .....No Yes Current
Hemorrhoids.....No Yes Current
Nervous Breakdown.....No Yes Current
Poisoning .....No Yes Current
Hay fever /Asthma.....No Yes Current
Hives or eczema .....No Yes Current
Frequent infections.....No Yes Current
HIV/AIDS .....No Current
Other_____

Alleriges:
Are you allergic to-
Penicillin..... No Yes
Sulfa .....No Yes
Aspirin.....No Yes
Codiene .....No Yes
Morphine.....No Yes
-Mycins.....No Yes
Other antibiotics.....No Yes
Merthiolate .....No Yes
Mercurochrome.....No Yes
Other_____
Foods_____
_____
_____
_____

Injuries: Have you had
Broken or cracked bones.....No Yes
Sprains/strains.....No Yes
Lacerations.....No Yes
Dislocations.....No Yes
Concussion or Head inj. .....No Yes
Ever knocked unconscious.....No Yes
Weight_____One year ago_____
Maximum_____ When_____

Transfusions: Have you ever had-
Blood or plasma transfusion...No Yes

Surgery: Have you had-
Tonsillectomy.....No Yes
Appendectomy.....No Yes
Other procedures.....No Yes
Type_____Year_____
Type_____Year_____
Type_____Year_____
Type_____Year_____
Type_____Year_____