



Bedford Natural Health Clinic

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Patient Confidential Information *(please print)*

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number (home) _____ (work) _____

May we leave messages concerning your visit on your answering machine at home phone? Yes No

Date of Birth: _____ Age: _____ Male Female

Occupation: _____ Hours per week: _____

Who can we call if we are unable to reach you? _____ Phone: _____

Relationship _____ Email: _____

Signature: _____ Date: _____

History of condition:

When and where did you last receive medical or health care? _____

What was the reason? _____

When was your last blood test? _____ Result? _____

What are your most important health issues? (List in order of importance)

1. _____
2. _____
3. _____
4. _____
5. _____

How long has your main problem been bothering you? _____

When was the first time you noticed this condition? _____

What do you suspect is causing your problem or contributing to it? _____

What treatment approaches have you tried? _____

Have you seen a Naturopathic Doctor before? Yes No

What was the therapy and the results? _____

Are you currently working with a Doctor of conventional medicine? (M.D. or D.O.): Yes No

List Diagnoses: _____

Family History: Please list ages, health problems and if deceased, the cause of death Mom's Father's

	Mother	Father	Brother	Sisters	Child	Grandparents
Age if living	_____	_____	_____	_____	_____	_____
Health (G=good, P=poor)	_____	_____	_____	_____	_____	_____
						Mom's Father's
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Epilepsy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Mental Illness	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Respiratory,	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Hayfever,	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Hives	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Anemia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Kidney Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Glaucoma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F
Tuberculosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	<input type="checkbox"/> Sisters	<input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F

Age at death/cause

Mother	Age: _____	Cause: _____
Father	Age: _____	Cause: _____
Brothers	Age: _____	Cause: _____
Sisters	Age: _____	Cause: _____
Child	Age: _____	Cause: _____
Grandparents	Age: _____	Cause: _____

What is your nationality? (Please list all backgrounds & give approximate %) _____

Do you have any blood relatives, Aunt, Uncle, Grandparent, **who has had:**

- | | | | | |
|---|---|-------------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Skin disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Genetic problems | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> sickle cells | <input type="checkbox"/> Arthritis |

The general state of your health is? Excellent Good Average Fair Poor

Please Check box if you have had any of the following Childhood illnesses:

- Scarlet Fever Diphtheria Rheumatic Fever Polio Measles Mono
 Mumps Smallpox German measles Chickenpox Whooping cough

Please Check box if you have had any of the following Immunizations:

- Polio Diphtheria Pertussis Measles/Mumps/Rubella Tetanus Shot (not anti-toxin) Hepatitis B

Hospitalizations and Surgery: Yes No

Please check special studies you have had: CAT scan MRI X rays other

Please list any abnormal lab results (include when and if you re-tested with a normal result): _____

Current Medications:

- Tranquilizers MAO inhibitor Appetite suppressants Calcium Channel Blocker
 Laxative Cortisone Pain relievers Antacids
 Sleeping pills Thyroid medication Diuretic Birth Control Pills

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking (give full name, dosage and how long you have been taking it, write on back if you need more space)

Prescription: _____

Over the Counter: _____

Vitamins: _____

Which of the following do you currently use?

Tobacco: Yes No, if YES, Packs per day _____ **Alcohol:** Yes No, if YES, _____ per week

Coffee: Yes No, if YES, Cups per day _____ **Soda:** Yes No, if YES, _____ per day

Sweetener: Yes No, if YES, _____ X per day
(Artificial)

Describe any exercise you currently do: _____

Do you eat three meals a day? Yes No

Do you sleep well? Yes No if YES, Number of hours per night? _____

Wake rested? Yes No

Do you enjoy your work? Yes No

Does anything you do at work make your condition worse? Yes No What? _____

Review of Systems:

General: Weight _____ Weight 1 year ago _____ Maximum weight _____ Height _____

Describe your energy level: Poor, OK Good Great

Is this a change in the last 6 months? Yes No

Please check the box: **Y (yes)** a condition you have now, **P (past)** a condition you have had before and **N (never)** had

Blood:

Anemia: Yes Past Never

Recent Blood Pressure: _____

Cardiovascular:

Heart Disease: Yes Past Never

Angina: Yes Past Never

High Blood Pressure: Yes Past Never

Murmurs: Yes Past Never

Chest Pain: Yes Past Never

Swelling in ankles: Yes Past Never

Palpitations: Yes Past Never

Ears:

Impaired Hearing: Yes Past Never

Ringing: Yes Past Never

Earaches: Yes Past Never

Dizziness: Yes Past Never

Emotional:

Depression: Yes Past Never

Mood Swings: Yes Past Never

Anxiety or nervousness: Yes Past Never

Tension: Yes Past Never

Endocrine:

Hypothyroid: Yes Past Never

Heat or cold intolerance: Yes Past Never

Excessive Thirst: Yes Past Never

Excessive hunger: Yes Past Never

Eyes:

Impaired Vision: Yes Past Never

Glasses/contacts: Yes Past Never

Eye pain: Yes Past Never

Tearing/dryness: Yes Past Never

Double vision: Yes Past Never

Glaucoma: Yes Past Never

Cataracts: Yes Past Never

Head:

Headache: Yes Past Never

Head Injury: Yes Past Never

Gastrointestinal:

Liver disease: Yes Past Never

Ulcer: Yes Past Never

Heartburn: Yes Past Never

Change in

Thirst: Yes Past Never

Appetite: Yes Past Never

Nausea: Yes Past Never

Vomiting: Yes Past Never

Vomit blood: Yes Past Never

Hemorrhoids: Yes Past Never

Belching/gas: Yes Past Never

Blood in Stool: Yes Past Never

Gall bladder Disease: Yes Past Never

Mouth/Throat:

Frequent sore throat: Yes Past Never

Sore Tongue: Yes Past Never

Gum problems: Yes Past Never

Hoarseness: Yes Past Never

Dental cavities: Yes Past Never

Musculoskeletal:

Joint pain or stiffness: Yes Past Never

Arthritis: Yes Past Never

Broken bones: Yes Past Never

Muscle Spasms/cramps: Yes Past Never

Weakness: Yes Past Never

Neck:

Lumps: Yes Past Never

Swollen Glands: Yes Past Never

Goiter: Yes Past Never

Pain or Stiffness: Yes Past Never

Trouble Swallowing: Yes Past Never

Neurologic:

Fainting: Yes Past Never

Seizures: Yes Past Never

Paralysis: Yes Past Never

Muscle weakness: Yes Past Never

Numbness or tingling: Yes Past Never

Loss of memory: Yes Past Never

Nose/Sinuses:

- Frequent colds: Yes Past Never
- Nose Bleeds: Yes Past Never
- Stiffness: Yes Past Never
- Hay fever: Yes Past Never
- Sinus problems Yes Past Never

Peripheral vascular:

- Deep Leg Pain: Yes Past Never
- Cold hands/feet: Yes Past Never
- Varicose veins: Yes Past Never

Respiratory:

- Cough: Yes Past Never
- Sputum: Yes Past Never
- Spit up blood: Yes Past Never
- Wheezing: Yes Past Never
- Asthma: Yes Past Never
- Bronchitis: Yes Past Never
- Pneumonia: Yes Past Never
- Pleurisy: Yes Past Never
- Emphysema: Yes Past Never
- Difficulty breathing: Yes Past Never
- Pain on breathing: Yes Past Never
- Tuberculosis: Yes Past Never
- Shortness of breath: Yes Past Never
 - At night? Yes Past Never
 - Lying down? Yes Past Never

Urinary:

- Pain on urination: Yes Past Never
- Increased frequency: Yes Past Never
- Frequency at night: Yes Past Never
- Inability to hold urine: Yes Past Never
- Frequent infections: Yes Past Never
- Kidney Stones: Yes Past Never

Skin:

- Rashes: Yes Past Never
- Eczema: Yes Past Never
- Acne: Yes Past Never
- Itching: Yes Past Never
- Color Change: Yes Past Never
- Lumps: Yes Past Never
- Night Sweats: Yes Past Never

Male Reproductive:

- Hernias: Yes Past Never
- Testicular Masses: Yes Past Never
- Testicular Pain: Yes Past Never
- Sexually Active: Yes Past Never
- Prostate Disease: Yes Past Never
- Venereal Disease: Yes Past Never
- Discharge or sores: Yes Past Never

Female Reproductive:

- Age Menses Began: _____
- If periods have stopped at what age? _____
- Average # of days long: _____
- Total Days in Cycle: _____

- Bleeding between: Yes Past Never
- Are cycles regular: Yes Past Never
- Pain during intercourse: Yes Past Never
- Painful menses: Yes Past Never
- Excessive flow: Yes Past Never
- Birth Control: Yes Past Never

Type:

- # of pregnancies: _____
- # of live births: _____
- # of miscarriages: _____
- # of abortions: _____

- Difficulty conceiving: Yes Past Never
- Menopausal Symptoms: Yes Past Never
- Sexually Active: Yes Past Never
- Venereal Disease: Yes Past Never

Breasts:

- Do you do self exam: Yes Past Never
- Lumps: Yes Past Never
- Pain or Tenderness: Yes Past Never
- Nipple Discharge: Yes Past Never

Any known allergies:

Bowel movement, how often: _____ Formed? _____ Mucous? _____

Has there been a change in your bowel movement recently? _____

Personal Habits

What do you enjoy most in your life? _____

What are your main interests or hobbies? _____

What do you worry most about in life? _____

Do you have a religious or spiritual practice: Yes No If yes, what? _____

Do you take vacations? Yes No

Do you take some extra time for yourself (Ex. receive massages, or other activities that include pampering yourself)
 Yes No

Are you currently in a happy satisfying relationship with someone? Yes No [Very, mostly, somewhat, not]

Occupational/household

How long have you lived at your present address? _____

Where have you lived previously? (Please describe location, if old or new place, i.e., new construction, damp or moldy)

Do you have specialized air filtration at home? Yes No Do the windows open? Yes No

Do you work in an office building? Yes No Do the window open? Yes No

Do you have specialized air filtration at your work place? Yes No

Do you work in the presence of toxic fumes or chemicals? Yes No

Do any of your hobbies involve toxic materials? Yes No

Are you exposed to second hand smoke currently? Yes No

What do you use for drinking water? Bottled filtered tap water

What percentage of the food you eat is organic? _____

Health Choices:

Which of the following would you like included in your health plan if appropriate?

- Vitamins Minerals Dietary Supplementation
- Homeopathy Botanicals Exercise
- Hydrotherapy Dietary Recommendations Stress management
- Other

What do you think is the most important part of your healing process? _____

Any other comments _____