

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Health History Summary**

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Blood Type \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (daytime or evening)

Email \_\_\_\_\_ Do you check it daily? (yes or no)

I DO NOT wish to receive Dr. Ted's Monthly Email Newsletter.

Gender: (Male or Female) Marital Status: (Single, Married, Divorced, Widowed, or Separated)

Occupation \_\_\_\_\_ (full or part time) Employer \_\_\_\_\_

Name of spouse (or parent for minor child) \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Dr. Ted Suzelis? \_\_\_\_\_

Last physician or health care provider seen? \_\_\_\_\_

When was your last blood test? \_\_\_\_/\_\_\_\_/\_\_\_\_ What kind? \_\_\_\_\_

**Your Current Health Problems**

What is your main reason for coming to our office? If you have a specific health condition, please describe it in detail. When was the very first time that you noticed your condition and describe carefully any factor that you suspect may have played a role in its onset and its continuation?

How long has your main problem been troubling you? \_\_\_\_\_

Is your current main problem getting (better, worse, same) and for how long? \_\_\_\_\_

List in order of importance other health problems that are troubling you:

1. \_\_\_\_\_ Length of Time \_\_\_\_\_

2. \_\_\_\_\_ Length of Time \_\_\_\_\_

3. \_\_\_\_\_ Length of Time \_\_\_\_\_

4. \_\_\_\_\_ Length of Time \_\_\_\_\_

Other Problems: \_\_\_\_\_

What kind of treatment have you received and from whom? \_\_\_\_\_

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health care provider for your current problem? (yes or no) or for any other problems? (yes or no)

What was the therapy and what were the results? \_\_\_\_\_

## Your Health History

The general state of your health is: (*excellent, good, average, fair, poor*)

What is your average energy level from 1-10? (10 is highest and 1 is lowest) \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ What level \_\_\_\_\_

When during the day is your energy the worst? \_\_\_\_\_ What level \_\_\_\_\_

What is your current approximate weight? \_\_\_\_\_ height? \_\_\_\_\_ Weight one year ago \_\_\_\_\_

As an adult, what has been your highest weight? \_\_\_\_\_ and lowest weight \_\_\_\_\_ (excluding pregnancy)

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant.

1. \_\_\_\_\_ date(s) \_\_\_\_\_

2. \_\_\_\_\_ date(s) \_\_\_\_\_

3. \_\_\_\_\_ date(s) \_\_\_\_\_

4. \_\_\_\_\_ date(s) \_\_\_\_\_

5. \_\_\_\_\_ date(s) \_\_\_\_\_

Are any of these situations continuing to impact your life? (*yes or no*)

Are you currently working with a professional counselor, psychologist, pastor or other therapist? (*yes or no*)

Have you in the past (*yes or no*) If so, when? (give dates) \_\_\_\_\_

Are you currently working with a Doctor of conventional medicine (M.D. or D.O.)? (*yes or no*)

If so, Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever had the following: (Circle "N" for No or "Y" for Yes, leave blank if uncertain)

Measles.....	N or Y	Anemia.....	N or Y	Back Trouble.....	N or Y	Hepatitis.....	N or Y
Mumps.....	N or Y	Bladder Infections...	N or Y	High Blood Pressure.	N or Y	Ulcer.....	N or Y
Chickenpox.....	N or Y	Epilepsy.....	N or Y	Low Blood Pressure..	N or Y	Kidney Disease.....	N or Y
Whooping Cough.....	N or Y	Migraine Headaches.	N or Y	Hemorrhoids.....	N or Y	Thyroid Disease.....	N or Y
Scarlet Fever.....	N or Y	Tuberculosis.....	N or Y	Bleeding Tendency...	N or Y	Any other disease.....	N or Y
Diphtheria.....	N or Y	Diabetes.....	N or Y	Asthma.....	N or Y	Please list: _____	
Smallpox.....	N or Y	Cancer.....	N or Y	Hives or Eczema.....	N or Y	_____	
Pneumonia.....	N or Y	Polio.....	N or Y	AIDS or HIV+.....	N or Y	_____	
Rheumatic Fever.....	N or Y	Glaucoma.....	N or Y	Infectious Mono.....	N or Y	_____	
Heart Disease.....	N or Y	Hernia.....	N or Y	Bronchitis.....	N or Y	_____	
Arthritis.....	N or Y	Blood/Plasma		Mitral Valve Prolapse	N or Y	_____	
Venereal Disease.....	N or Y	Transfusions.....	N or Y	Stroke.....	N or Y		

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
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Do you have any known allergies to any drugs, foods, animals, herbs, or other (*yes or no*) What? \_\_\_\_\_

**Which of the following do you currently use?** (list how often, how much and how long for each)

Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_  
Hormones \_\_\_\_\_ Coffee \_\_\_\_\_  
Cortisone \_\_\_\_\_ Laxatives \_\_\_\_\_  
Sedatives \_\_\_\_\_ Antacids \_\_\_\_\_

Other medications (please give full name, dosage, and how long you have been taking the medication)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Vitamins or Herbs (please give full name, dosage, and how long you have been taking them)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Family History**

Please list ages, health problems, and if deceased, cause of death:

	Age	Health Problems	Age Died	Cause
Your Mother	_____	_____	_____	_____
Your Father	_____	_____	_____	_____
Your Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Your Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Mother's Mom	_____	_____	_____	_____
Mother's Dad	_____	_____	_____	_____
Father's Mom	_____	_____	_____	_____
Father's Dad	_____	_____	_____	_____
Your Spouse	_____	_____	_____	_____

What is your nationality? \_\_\_\_\_

Do you have any children? (*yes or no*) How many? \_\_\_\_\_ Have you ever had toxemia during pregnancy? (*yes or no*)

Do they have any health problems? \_\_\_\_\_

Do you have any aunt, uncle, grandparent or other blood relative who has had any of the following?

Allergies \_\_\_\_\_ Arthritis \_\_\_\_\_ Asthma \_\_\_\_\_ Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_  
Anemia \_\_\_\_\_ Depression \_\_\_\_\_ Skin disease \_\_\_\_\_ Heart attack \_\_\_\_\_ Genetic problems \_\_\_\_\_  
High B.P. \_\_\_\_\_ Stroke \_\_\_\_\_ Ulcers \_\_\_\_\_ Cataracts \_\_\_\_\_ Thyroid problem \_\_\_\_\_  
Hypoglycemia \_\_\_\_\_ Seizures \_\_\_\_\_ Sickle cells \_\_\_\_\_ Venereal disease \_\_\_\_\_

What is your weakest organ system and why? \_\_\_\_\_

## 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 exercise? (*yes or no*) If yes, what kind, how much & how often? \_\_\_\_\_  
Do you have a religious or spiritual practice? (*yes or no*) If yes, what? \_\_\_\_\_  
On a scale of 1-10, how would you rate the quality of your sleep (10 being great) \_\_\_\_\_  
Do you have problems (*falling or staying asleep*)? \_\_\_\_\_ How many hours do you sleep at night? \_\_\_\_\_  
Do you awaken at night? (*yes or no*) If yes, what time(s) do you usually wake up? \_\_\_\_\_  
Do you ever sweat at night while sleeping? (*yes or no*) How frequently and how much do you sweat? \_\_\_\_\_ Do you wake up feeling refreshed? (*yes or no*).  
Do you nap or rest horizontally during the day? (*yes or no*) For how long? \_\_\_\_\_  
What do you normally feel like temperature wise, compared to others? (*warmer, cooler, or average*)  
What are the temperatures of your hands and feet generally? (*warmer, cooler, or average*)  
Do you enjoy your work? (*yes or no*) Do you take vacations? (*yes or no*)  
Are you currently in a happy, satisfying relationship with someone? (*Very, mostly, somewhat, not*)  
How often do you get colds, flus, sore throats, yeast infections during the year? \_\_\_\_\_  
When you rise quickly from a sitting or lying position, do you ever get dizzy? (*yes or no*)  
If yes, how often? (*daily, few times per week, 1 time/week, 2 times/month, 1 time/month, rarely*)  
What are your health goals for 1 year from now? \_\_\_\_\_  
What are your health goals for 5 years from now? \_\_\_\_\_  
On a scale of 1-10, how would you rate your happiness in life? (10 = loving life) \_\_\_\_\_

## Female Reproduction

Age of first menses \_\_\_\_\_ If periods have stopped, at what age did they stop? \_\_\_\_\_  
Are your cycles regular? (*yes or no*) Period begins every \_\_\_\_\_ days. How long does period last? \_\_\_\_\_  
Are your periods (*Heavy, medium, light*) and what color is blood? (*light red, dark red, medium, clots*)  
Do you have any spotting or bleeding between periods? (*yes or no*) Any cramps with periods? (*yes or no*)  
Do you have any premenstrual symptoms? (*water retention, breast tenderness, irritability, depression, mood swings, food cravings*) other \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_ Number of abortions \_\_\_\_\_ Number of live births? \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_ Any problems getting pregnant? \_\_\_\_\_  
Do you get annual PAP smears? (*yes or no*) Any abnormal PAP's? (*yes or no*) Breast lumps? (*yes or no*)  
Any questions or problems concerning sex? \_\_\_\_\_  
Any pain or discomfort with sexual intercourse? (*yes or no*)  
Are you currently sexually active? (*yes or no*) How often? \_\_\_\_\_ Is this (*more or less*) than 1 year ago?  
Do you use birth control? (*yes or no*) What type of birth control do you use? \_\_\_\_\_  
Have you ever been physically or sexually abused? (*yes or no*) How old and how often? \_\_\_\_\_

## Male Reproduction

How often do you have to get up at night to urinate? \_\_\_\_\_ Is this an increase in past few years? (*yes or no*)  
Any problems with impotency? (getting or maintaining an erection) (*yes or no*) Any sores on penis? (*yes or no*)  
Do you have any abnormal discharge from the penis? (*yes or no*) Any venereal diseases? (*yes or no*)  
Any prostate problems? (*yes or no; past/now*) Ever have your prostate examined? (*yes or no*) When? \_\_\_\_\_  
Are you currently sexually active? (*yes or no*) How often? \_\_\_\_\_ Is this (*more or less*) than 1 year ago?  
Do you use birth control? (*yes or no*) What type of birth control do you use? \_\_\_\_\_  
Have you ever been physically or sexually abused? (*yes or no*) How old and how often? \_\_\_\_\_

## Digestion

Do you have any problems with gas, bloating or fullness after eating? (*yes or no*). How often do you have gas, fullness or bloating after eating? (*often, sometimes, never*). How severe? \_\_\_\_\_

Do you have gas in (*upper part of the abdomen/belching or lower part/flatulence or both areas*)? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

How often do you have bowel movements? \_\_\_\_\_

Do you ever have any (*blood, mucous, undigested food, black*) stools?

Any anal/rectal itching? (*yes or no*) Do your stools tend to be (*formed or loose*)? How often do you have diarrhea? \_\_\_\_\_ Do you ever have alternating constipation and diarrhea? (*yes or no*)

How often do you have thin, long and narrow stools? (*often, sometimes, never*)

How often do you have small & hard stools? (*often, sometimes, never*)

Do you ever have yellow or light colored stools? (*often, sometimes, never*)

How often do your stools have a strong disagreeable odor? (*often, sometimes, never*)

Have you ever fasted? (*yes or no; juice or water*) For how long have you fasted? \_\_\_\_\_

How did you feel while you were fasting? \_\_\_\_\_

Have you traveled outside the U.S. in last 5 years? (*yes or no*)

Have you gone camping in last 5 years? (*yes or no*)

## Kidneys and Bladder

Have you had recurrent bladder infections? (*yes or no*) How were they treated? \_\_\_\_\_

How many bladder infections have you had in the last 3 years? \_\_\_\_\_

Do you ever have any burning sensation during or after urination? (*past or present*)

Is your urine (*dark yellow, bright yellow, cloudy, pale or clear*)?

Does your urine have a strong odor to it? (*yes or no*)

Do you have difficulty starting or stopping when urinating? (*yes or no*)

Do you have difficulty perspiring? (*yes or no*). Do you perspire when you exercise? (*light, moderate, heavy*)

Do you perspire other times than when exercising? (*yes or no*) When? \_\_\_\_\_

Does your perspiration have a strong smell? (*yes or no*)

Does your temperature tend to run (*low, high or average*) compared to others?

How much water do you drink daily? \_\_\_\_\_

What other beverages do you drink daily and how much? \_\_\_\_\_

## Occupational/Household

How long have you lived at your present address? \_\_\_\_\_

Is the location (*old or new construction*)?; Is it (*damp, moldy, dry or dusty*)?

Where have you lived previously? \_\_\_\_\_

Was the location (*old or new construction*)?; Was it (*damp, moldy, dry or dusty*)?

Do you have specialized air filtration at home? (*yes or no*). Do you live in the city? (*yes or no*)

Do you work in an office building? (*yes or no*). Do the windows open? (*yes or no*)

Do you have specialized air filtration at your work place? (*yes or no*)

Do you work in the presence of toxic fumes or chemicals? (*yes or no*)

Do any of your hobbies involve toxic materials? (*yes or no*)

Are you exposed to second hand smoke on a regular basis, presently? (*yes or no*)

What do you use for your drinking water? (*bottled, filtered, or tap water*)

**Do you have anything else you would like to comment on?**

Dr. Ted Suzelis, N.D.  
725 Boardman-Canfield Rd., #K4, Boardman, OH 44512  
38 W. Broad Street, Newton Falls, OH 44444

### Informed Consent Form

I, \_\_\_\_\_ hereby solicit the services of Dr. Ted Suzelis, N.D. in good faith, exercising my free will and following the dictates of my own conscience, which allows me to contract for what I believe to be most beneficial for me. I am not obligated to continue utilizing the services of Dr. Ted Suzelis, N.D. and may discontinue the use of these services at any time. The choice I make in contracting for these services is not to be overridden by any family member, court of law, medical facility or other physician, and I charge same to honor this contract.

I understand that Dr. Ted Suzelis, N.D. is not a Medical Doctor (M.D.), an Osteopathic Doctor (D.O.) or a Chiropractor (D.C.). I also understand that Dr. Suzelis is not a licensed physician in the State of Ohio, because Ohio does not license Naturopathic Physicians. He does, however, hold a license as a Naturopathic Physician (N.D.) in the State of Vermont. I am aware that because he is not licensed in the State of Ohio, he will not diagnose, treat or cure any disease that I may have. His services are to help me improve my health to allow my body to heal itself. Dr. Suzelis expects that I will continue care with my Medical Doctor, as his services are not a substitute for medical care. He will also never make recommendations that I discontinue any medications that have been prescribed to me by my Medical Doctor. Dr. Suzelis also is not able to bill insurance for any services that are provided to me.

I agree to indemnify, protect, save and hold harmless Dr. Ted Suzelis, N.D. from any and all liability for any and all complications of any nature should they arise whether to myself or to any minor and/or incompetent for who I am legally claiming responsibility and hereby charge my heirs to honor this agreement.

I further state that I do not now, nor have I ever, worked for any city, county, state, federal government agency or associations for entrapment or investigative purposes of health care practitioners. I also acknowledge that under the Bivens Act, Article 42, I will be held personally and individually liable for any cost to Dr. Ted Suzelis, N.D. that may result from my visit.

I have fully read and understand the above information, my responsibilities and rights and hereby contract to employ the services available with Dr. Ted Suzelis, N.D. I am willing to declare and repeat under oath all of the above statements at the attending practitioners request.

Signature \_\_\_\_\_ Date \_\_\_\_\_