Date____/____/_____

Ohio Naturopathic Health History

Name_____ Age_____ Birthdate____/____/_____ Blood Type_____

Address_____ City_____ State_____ Zip_____

Phone (Home) _____ (Cell) _____ (Other) _____

Email_____ Preferred Contact Method: (Home, Cell, Other, Text, Email)

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

□ Please check if you do not wish to receive Dr. Ted's Monthly Email Newsletter.

□ Please check if you do not wish to receive updates from the OCAANP on Naturopathic Medicine in Ohio.

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 is your interest level in the following therapies? 0 = No Interest to 5 = Extreme Interest

Nutritional/Dietary Recommendations: ____ Vitamins/Nutritional Supplements: ____

Herbal Medicine: ____ Homeopathy: ____ Acupuncture: ____ Chiropractic: ____ Whatever Works: ____

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

_____

_____

_____

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 retension, 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*)
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*)
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?



OHIO NATUROPATHIC WELLNESS CENTER

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(330) 729-1350 | www.ohionaturopathic.com

HEALTH CARE SERVICES CONTRACT

Welcome to Ohio Naturopathic Wellness Center! We provide individualized care that addresses the whole person, focuses on prevention, and assists you in achieving an optimal level of health. This document contains important information about professional services and business practices. Please read it carefully and ask any questions you have about the information.

NON-MEDICAL AND COMPLEMENTARY NATURE OF SERVICES

I understand that Dr. Ted Suzelis, ND and Dr. Rachael O'Connell, ND are not medical doctors and that naturopathy is not a medical specialty but a separate and distinct health care tradition. I understand that Dr. Suzelis is a licensed naturopathic physician in the State of Vermont and Dr. O'Connell is a licensed naturopathic physician in the State of Arizona, based upon their four-year medical school training at accredited naturopathic medical schools. The State of Ohio does not currently offer naturopathic physician licensing. Where naturopathic physicians are not licensed, their scope of practice does not encompass the diagnosis and treatment of disease, but is focused upon consultations regarding natural remedies. Consultations with Dr. Suzelis or Dr. O'Connell may include discussion of nutritional issues and of diet, nutrition and supplementation, such as the use of dietary supplements and botanical substances; homeopathic remedies; mind-body supportive counseling; and promotion of healthy lifestyles and wellness.

PROFESSIONAL FEES

Fees for services are to be paid at each appointment unless other arrangements have been made prior to my appointment. I fully understand that a 24-hour cancellation notice is required for all scheduled visits and that I am responsible for a cancellation fee of $50.00 if I fail to keep my scheduled appointment without at least 24 hours' notice. I also understand that, with few exceptions, my services will not be reimbursed by insurance or Medicare and Ohio Naturopathic Wellness Center does not accept insurance. Insurance generally provides reimbursement only when services are delivered by individuals licensed to provide health care services in the state in which care is delivered.

CONFIDENTIALITY

All information provided on the health questionnaire/intake form or during office visits or any other correspondence is confidential. Any information provided to our office will not be released without your written consent, including providing information to other caregivers, except as otherwise required or permitted by law. The applicability of HIPAA privacy regulations depends on the practice's activities and legal status.

NATURAL SUBSTANCES

If I am given the opportunity to purchase any supplements and other products from Ohio Naturopathic Wellness Center, I understand that I am under no obligation to purchase these products from Ohio Naturopathic Wellness Center and I will be given the same level of attention without regard to my purchases. I understand that Dr. Ted Suzelis, ND and/or Dr. Rachael O'Connell, ND may profit from the sale of supplements and other products made available to patients, as applicable.

NO GUARANTEES

I am aware that naturopathic medicine is an art and that there are wide individual differences in responses to these services. No guarantees are made that I will gain any benefit or not suffer any adverse consequences. In the event that a dispute arises that we cannot resolve amicably, I understand that neither Dr. Suzelis nor Dr. O'Connell is practicing medicine in Ohio and that, if a legal case is brought, I agree that their services shall be evaluated by the standards and principles of complementary, alternative, and/or holistic care rather than the standards of consensus conventional medicine.

INFORMED CONSENT

I hereby authorize naturopathic assessment and consultation by Dr. Ted Suzelis, ND and/or Dr. Rachael O'Connell, ND and certify that I understand the nature of this health care method, including the risks of possible adverse reactions and choices I may have about other approaches. I understand that no recommendations are being made to me to discontinue any treatment being provided by any other health care professional. I understand that neither practitioner functions as my primary care or medical physician and that these services complement other services I receive. I have been adequately informed, and questions I have asked have been satisfactorily answered. I represent that I am seeking assessment and consultation in order to further my own health and for no other reason and do not represent a third party. I sign this voluntarily and am aware that I may withdraw this consent and discontinue following the recommendations at any time.

I have read this form and agree to all its contents with my signature below.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____
(Signature of patient, or one parent or guardian if patient is under 18)