Dr. Vivian Lord, N.D.
NATUROPATHIC DOCTOR
Natural Approaches to Women's Health

Adult Health Questionnaire

*Please scan and email form to **info@drvivianlord.comor** or send by mail once completed*

Name: (*Last*) _____ (*First*) _____ (*Middle Initial*) _____

Date (*mm/dd/yyyy*): _____

Address: _____

City: _____ State/Province: _____ Zip/Postal code: _____

Telephone # (Home): _____ Alt. #: _____ (*Circle primary*)

E-mail Address: _____ Skype username (*if requesting Skype appointments*): _____

Date of Birth: (*mm/dd/yyyy*) _____ Age: _____ Gender: Female _____ Male _____

Marital Status: S M W D (circle one) # of children: _____

Occupation: _____ Hours per week: _____ Retired: _____

Employer: _____ Work #: _____

Work Address: _____

Next of kin or other to reach in case of an emergency: _____

Relationship: _____ Phone #: _____

Address: _____

Medical Doctor:

Name: _____ Telephone: _____

Address: _____

Date of Last Appointment: _____ Date of Last physical: _____

Date of Last Dental Exam: _____

How did you hear about Dr. Lord? _____

CONTEXT OF CARE REVIEW

Successful health care and wellness are only possible when the healthcare provider has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) a) Why did you choose to see Dr. Lord?

b) What do you know about her approach?

2) a) What three expectations do you have from this first appointment?

b) What long term expectations do you have of me personally as your healthcare provider?

3) What is your present level of commitment to address any underlying causes of your sign and symptoms that relate to your lifestyle? (Rate from 0 – 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are less constructive lifestyle habits? (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that we will be sharing with you?

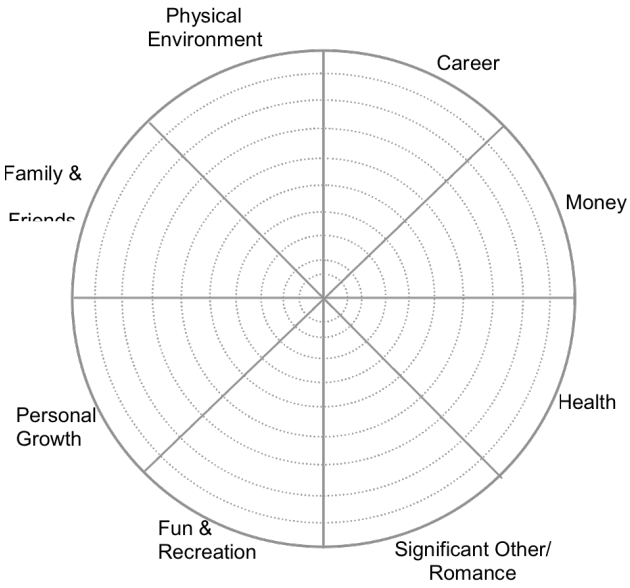
6) Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

WHEEL OF BALANCE

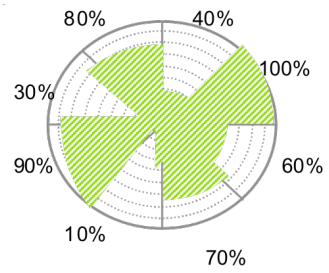
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for the career.

Start at the center point and fill in toward the outside of the pie. Do the same for each area in your life.



Example



What are your most important health problems? List as many as you can in order of importance:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

What are your most important health goals?

1) _____
2) _____
3) _____

FAMILY HISTORY

Do you have a family history of any of the following? (please fill in all applicable boxes)

	Relationship	Comments		Relationship	Comments
Allergies			Heart disease		
Anemia			Hepatitis		
Arthritis			High blood pressure		
Auto immune disease			Kidney disease		
Asthma			Mental illness		
Cancer			Stroke		
Diabetes			Tuberculosis		
Epilepsy			Other		

Any other relevant family history? _____

CHILDHOOD ILLNESSES

Please circle whether you had any of these as a child:

Scarlet fever	Rheumatic fever	Measles
Diphtheria	Mumps	German measles

ALLERGIES

Are you hypersensitive or allergic to…

Drugs? _____

Foods? _____

Environmental or chemical? _____

HOSPITALIZATIONS, SURGERY, IMAGING

What hospitalizations, surgeries, X-Rays, CT scans, EEG, EKG's have you had?

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

CURRENT MEDICATIONS & SUPPLEMENTS

Do you take or use? (Circle Yes or No)

Pain Relievers	Y N	Laxatives	Y N	Antibiotics	Y N
Appetite suppressants	Y N	Cortisone	Y N	Tranquilizers	Y N
Thyroid Medication	Y N	Sleeping Pills	Y N	Antacids	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking

1) _____ Dosage: _____
2) _____ Dosage: _____
3) _____ Dosage: _____
4) _____ Dosage: _____
5) _____ Dosage: _____
6) _____ Dosage: _____
7) _____ Dosage: _____
8) _____ Dosage: _____

PRIOR/CURRENT CARE BY CONSERVATIVE HEALTHCARE:

(Chiropractic/ Naturopath/Massage/ Other)

Name: _____ Telephone: _____
Comments: _____

GENERAL

Height: _____ Weight: _____ Weight 1 year ago: _____ lbs
Maximum Weight: _____ When: _____
When during the day is your energy the best? _____ Worst? _____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

HABITS

FOR THE FOLLOWING, PLEASE CIRCLE

Y = Presently have N = Never had P = Significant problem in the past

Main exercise and hobbies: _____

Do you exercise	Y	N	Enjoy your work	Y	N
If yes, what kind? _____			Take vacations	Y	N
- How often _____			Spend time outside	Y	N
Average 6-8 hrs sleep	Y	N	Watch television	Y	N
Sleep well	Y	N	- How many hours/week _____		
Awaken rested	Y	N	Read	Y	N

Have a supportive relationship	Y	N		- How many hours/week _____			
Have a history of abuse	Y	N		Do you eat 3 meals a day	Y	N	
Any major traumas	Y	N	P	Do you go on diets often	Y	N	
Use recreational drugs	Y	N	P	Do you eat out often	Y	N	
Been treated for drug dependence	Y	N	P	Do you drink coffee	Y	N	P
Treated for alcoholism	Y	N	P	Drink black/green tea	Y	N	P
Do you use tobacco	Y	N	P	Do you drink soda	Y	N	P
Smoked previously?	Y	N		Do you eat refined sugar	Y	N	P
- How many years _____				Do you add salt	Y	N	P
- How many packs per day _____				Any foods you crave: _____			
				Any dietary restrictions or regimens you follow: _____ _____			

REVIEW OF SYSTEMS

Y = Presently have N = Never had P = Significant problem in the past

I

General

Chills or fever	Y	N	P	Unusual weight loss	Y	N	P
Unusual weight gain	Y	N	P	Night sweats	Y	N	P
Swollen lymph nodes	Y	N	P	Weakness or fatigue	Y	N	P

Mental/ Emotional

Treated for emotional problems	Y	N	P	Depression	Y	N	P
Mood swings	Y	N	P	Anxiety or nervousness	Y	N	P
Considered/ Attempted suicide	Y	N	P	Tension	Y	N	P
Poor concentration	Y	N	P	Memory problems	Y	N	P

Endocrine

Hypothyroid	Y	N	P	Heat or cold intolerances	Y	N	P
Hypoglycemia	Y	N	P	Diabetes	Y	N	P
Excessive thirst	Y	N	P	Excessive hunger	Y	N	P
Fatigue	Y	N	P	Seasonal depression	Y	N	P
Hair texture change	Y	N	P				

Neurologic

Seizures	Y	N	P	Paralysis	Y	N	P
Muscle weakness	Y	N	P	Numbness or tingling	Y	N	P
Loss of memory	Y	N	P	Easily stressed	Y	N	P
Vertigo or dizziness	Y	N	P	Loss of balance	Y	N	P

Skin

Rashes	Y	N	P	Eczema, Hives	Y	N	P
Acne, Boils	Y	N	P	Itching	Y	N	P
Color change	Y	N	P	Perpetual hair loss	Y	N	P
Lumps or growths	Y	N	P	Night sweats	Y	N	P
Bruise easily	Y	N	P	Unusually dry			

Head

Headaches	Y	N	P	Head injury	Y	N	P
Migraines	Y	N	P	Jaw/TMJ problems	Y	N	P
					Y	N	P

Eyes

Spots in eyes	Y	N	P	Cataracts	Y	N	P
Impaired vision	Y	N	P	Glasses or contacts	Y	N	P
Blurriness	Y	N	P	Eye pain/strain	Y	N	P
Color blindness	Y	N	P	Tearing or dryness	Y	N	P
Double vision	Y	N	P	Glaucoma	Y	N	P

Ears

Impaired hearing	Y	N	P	Ringing	Y	N	P
Earaches	Y	N	P	Dizziness	Y	N	P

Nose and Sinuses

Frequent colds	Y	N	P	Nose bleeds	Y	N	P
Stuffiness	Y	N	P	Hayfever	Y	N	P
Sinus problems	Y	N	P	Loss of smell	Y	N	P

Mouth and Throat

Frequent sore throat	Y	N	P	Copious saliva	Y	N	P
Teeth grinding	Y	N	P	Sore tongue/lips	Y	N	P
Gum problems	Y	N	P	Hoarseness	Y	N	P
Dental cavities	Y	N	P	Jaw clicks	Y	N	P

Neck

Lumps	Y	N	P	Swollen glands	Y	N	P
Goiter	Y	N	P	Pain or stiffness	Y	N	P

Respiratory

Cough	Y	N	P	Sputum	Y	N	P
Spitting up blood	Y	N	P	Wheezing	Y	N	P
Asthma	Y	N	P	Bronchitis	Y	N	P
Pneumonia	Y	N	P	Pleurisy	Y	N	P
Emphysema	Y	N	P	Difficulty breathing	Y	N	P
Pain on breathing	Y	N	P	Shortness of breath	Y	N	P
Shortness of breath at night	Y	N	P	Shortness of breath lying down	Y	N	P

Cardiovascular

Heart disease	Y	N	P	Angina	Y	N	P
High/Low blood pressure	Y	N	P	Murmurs	Y	N	P
Blood clots	Y	N	P	Fainting	Y	N	P
Phlebitis	Y	N	P	Palpitations/ Fluttering	Y	N	P
Rheumatic fever	Y	N	P	Chest pain	Y	N	P
Swelling in ankles	Y	N	P				

Gastrointestinal

Trouble swallowing	Y	N	P	Heartburn	Y	N	P
Change in thirst	Y	N	P	Abdominal pain or cramps	Y	N	P
Change in appetite	Y	N	P	Belching or passing gas	Y	N	P
Nausea/ vomiting	Y	N	P	Constipation	Y	N	P
Ulcer	Y	N	P	Diarrhea	Y	N	P
Jaundice (yellow skin)	Y	N	P	Bowel movments: how often: _____			
Gall bladder disease	Y	N	P	- is this a change? _____			
Liver disease	Y	N	P	Black in stool	Y	N	P
Hemorrhoids	Y	N	P	Blood in stool	Y	N	P

Urinary

Pain on urination	Y	N	P	Increase frequency	Y	N	P
Frequency at night	Y	N	P	Inability to hold urine	Y	N	P
Frequent infections	Y	N	P	Kidney stones	Y	N	P

Musculoskeletal

Joint pain or stiffness	Y	N	P	Arthritis	Y	N	P
Broken bones	Y	N	P	Weakness	Y	N	P
Muscle spasms or cramps	Y	N	P	Sciatica	Y	N	P
Loss of muscle mass	Y	N	P				

Blood/ Peripheral Vascular

Easy bleeding or bruising	Y	N	P	Anemia	Y	N	P
Deep leg pain	Y	N	P	Cold hand/feet	Y	N	P
Varicose veins	Y	N	P	Thrombophlebitis	Y	N	P

Male Reproductive

Hernias	Y	N	P	Prostate disease	Y	N	P
Testicular pain	Y	N	P	Discharge or sores	Y	N	P
Venereal disease	Y	N	P	Chlamydia	Y	N	P
Are you sexually active	Y	N	P	Gonorrhea	Y	N	P
Impotence	Y	N	P	Condyloma	Y	N	P
Premature ejaculation	Y	N	P	Herpes	Y	N	P
Birth control? Type _____				Syphilis	Y	N	P
Testicular masses	Y	N	P				

Female Reproduction/Breasts

Age of first menses _____				Date of last annual exam/ PAP	Y	N	P

Age of last menses (if menopausal) _____				- Are cycles regular?	Y	N	
Days between period	_____days			Bleeding between cycles	Y	N	P
Duration of period	_____ days			Pain during intercourse	Y	N	P
Painful menses	Y	N	P	Clotting	Y	N	P
Heavy or excessive flow	Y	N	P	Discharge	Y	N	P
PMS	Y	N	P	Birth control	Y	N	P
If yes, what are your symptoms? _____ _____				- What type _____			
				Number of pregnancies:			
Endometriosis	Y	N	P	Number of live births:			
Ovarian cysts	Y	N	P	Number of miscarriages:			
Difficulty conceiving	Y	N	P	Number of abortions:			
Cervical dysplasia	Y	N	P	Menopausal symptoms	Y	N	P
Sexual difficulties	Y	N	P	Abnormal PAP	Y	N	P
Gonorrhoea	Y	N	P	Chlamydia	Y	N	P
Herpes	Y	N	P	Condyloma	Y	N	P
Are you sexually active	Y	N	P	Syphilis	Y	N	P
Do you so self breast exams	Y	N	P	Breast lumps	Y	N	P
Breast pain/tenderness	Y	N	P	Nipple discharge	Y	N	P

Is there anything else you would like to add or comment on?

Thank you for your time and effort!
I look forward to providing you with the best possible care.

*One you have completed this form please scan and email it to **info@drvivianlord.com**, send by mail or bring it with you to your first appointment.*