



Please complete this form as best as you can. It is detailed, please be honest.

Name: _____ Age: ____ Date: _____

I was recommended by: _____

Occupation: _____ Hours spent working? _____

Weight: _____ your ideal weight: _____ Height _____

Blood Pressure _____ Pulse/heart rate _____ PH _____ Temperature _____

Your current Medical Doctor/address/phone:

Last medical visit: _____

What kind of health tests have you had in the past 1-2 years?

Could you obtain a copy of any current tests and send them to us? Y / N

What has been your past medical diagnosis?

Why are you seeking *a wellness consultation with a Naturopath Doctor* or Wellness Doctor? Main concerns you would like us to help you with.

Check all that apply. A physician or health practioner informed me that I have:

Overweight ___ Cancer ___ HPB ___ Diabetes ___ Immune Problems ___
Hepatitis ___ Arthritis ___ Stroke ___ Cholesterol ___ Mononucleosis ___
Migraines ___ Asthma ___ CFS ___ Allergies ___ Fibromyalgia ___
Thyroid ___ Seizures ___ Heart ___ Pneumonia ___ Depression ___
Sexually Transmitted Disease ___ Addictions: ___

Other: _____

Your Family History: Parents/Siblings:

Diabetes ___ Heart ___ Asthma ___ Seizures ___ Allergies ___
HBP ___ Stroke ___ Cancer ___ Weight Problems ___
Psychological ___ Cholesterol ___ Arthritis ___ Alcoholism ___ Neurological ___
Other health issues: _____

LIST ALL MEDICATIONS AND OR DIETARY SUPPLEMENTS THAT YOU TAKE:

Describe any *trauma*: (Car Accidents, Falls, etc.)

If you have health problems, how long ago did you begin to notice a change?

Be specific.

On a scale from 1- 10 rate yourself: (10) Great, (1) poor. Please complete:

My energy is: _____

My stress level is: _____

My emotional health is: _____

My physical health is: _____

Have you seen other Alternative Doctors or Therapists? **Y / N**
If so, what kind of provider?

Other health providers you have seen over the last few years:

Do your problems interfere with your daily lifestyle? **Y/N** Sleep/Sex/Work/ Explain:

What kind of treatments have you tried to improve your problems?

Please check if you experience any of the following:

Fevers ___ Poor Sleep ___ Sweat Easily ___ Strong Thirst ___
Poor Energy ___ Chills ___ Tremors ___ Poor Balance ___
Cravings ___ Weight Gain ___ Weight Loss ___ Depression ___
Localized Weakness ___ Memory Problems ___ Sore Throats ___ Headaches ___

What are three things that you would *want to improve or change in your life*?

1. _____
2. _____
3. _____

NOSE, HEAD, EARS, THROAT, AND MOUTH

Airway/ nasal cavity appears: can you breathe easily through your nose? Yes / No

I have the following:

Sinus Problems ___ Nose Bleeds ___ Difficulty Breathing ___ Snoring ___
Earaches ___ Headaches ___ Migraines ___ Ringing In Ears ___
Dizziness ___ Grinding Teeth ___ Jaw Clicks ___ Facial Pain ___
Sores On Lips ___ Past ENT Surgery: _____

Do you have a throat condition or recurring sore throats? **Y/N**

Have you had your tonsils/adenoids removed? **Y/N**

Ears: is there a crease on your ear lobe? **Y/N**

Tongue condition appears describe what you see: _____

Have you visited a dentist in 12 months? **Y/N**

List any **teeth or gum** problems:

Do you have any of the following?

Mercury Fillings __ Composites __ Sealants __ Crowns __ Metal __
Bridges __ Partial __ Root Canals __ Jaw Cavitat __ Implants __

Other Treatments:

Any difficulty with swallowing? **Y/N** Abnormal Swallow __ Can't Swallow Pills __

EYES: Iris overall appearance, constitutional type/subtype/vitality – Dr. Kopin -exam

My eye color is: _____

EYES

Glasses __ Poor Vision __ Cataracts __ Night Blindness __ Blurry vision __

Have you had eye surgery? **Y/N** Other: _____

NAILS/SKIN

Nails appear: Chewed/White Spots/Weak/Ridges/Discolored/Yellow

Refer to Dr. Chi's educational poster.

Do you experience any of the following changes to the skin?

Ulcers __ Hives __ Itching __ Eczema __ Pimples __
Moles __ Warts __ Loss of Hair __ Psoriasis __ Dandruff __
Sweating __ Cold Hands __ Bruise Easily __ Dry Skin __ Skin Cancer __

Varicose Veins: __ Other: _____

Do you have any oral habits? **Y/N** (Nail Biting/Thumb Sucking/Pulling Out Hair/
Smoking) Other:

URINARY

Decrease In Flow ___ Hard To Hold Urine ___ Pain ___ Urgency ___
Kidney Stones ___ Sores on Genitals ___ Blood In Urine ___
How frequent do you urinate daily? _____ x Do you wake up to urinate? Y/N
Color of your urine? _____

GASTROINTESTINAL

Bowel Conditions/Frequency per Day _____
Constipation ___ Black Stools ___ Nausea ___ Abdominal Pain ___
IBS ___ Gas ___ Vomiting ___ Diarrhea ___
Belching ___ Hemorrhoids ___ Indigestion ___ Past GI Tests ___
Hiccups ___ Burning Feeling ___ Past Colonic Therapy ___

MUSCULOSKELETAL

Muscle Pain ___ Muscle Weakness ___ Knee Pain ___ Neck Pain ___
Back Pain ___ Hip Pain ___ Shoulder Pain ___ Foot/Ankle Pain ___
Scoliosis ___ Hand/Wrist Pain ___ Head/Neck Musculature Soreness ___
Other joint/bone problems? _____

Do you experience reactions to:

Dust ___ Peanuts ___ Fruits ___ Chocolate ___ Alcohol ___
Pollen ___ Mold ___ Caffeine ___ Grass ___ Trees ___
Dairy ___ Wheat ___ Fuel ___ Eggs: ___
Other _____

PSYCHOLOGICAL/EMOTIONS

Mood Swings ___ Depression ___ Anxiety ___ Anger ___ Temper ___
Easily Stressed ___ Worry easily ___ Weight Loss ___ Memory Problems ___

Have or are you being treated for emotional problems? Y/N

Have you ever considered or attempted suicide? Y/N

How many hours per week do you devote to time for yourself? _____

Are you happy or satisfied with your family life? Y/N

Are you happy or satisfied with your work life? Y/N

At work do you get to use your strengths to do what you do best? Y/N

Is your working environment positive? Y/N

Is your religion an important part of your life? Y/N

Do you understand that your biography and past have much to do with your health? Y/N

Do you look at life as a gift or a chore? _____

How many hours do you sleep at night? _____

Do you worry about money often? **Y / N**

Are you aware that many pharmaceutical drugs can suppress and depress the bodies' normal defenses, instead of helping stimulate one's natural immunity? **Y/ N**

Are you aware that pharmaceutical drugs may cause toxicity and side effects? **Y /N**

DIETARY HISTORY

Please write down common daily eating and drinking patterns for one day.

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Have you ever been on a restricted diet? **Y/N**

Do you want to learn how to get healthy? **Y/N**

Are you willing to accept full responsibility for your health? **Y/ N**

Are you willing to prepare more meals at home? **Y/N**

Do you understand that whole foods, vitamins, and supplements are important when treating disease? **Y/N**

Do you understand restoring your body back to health will take some time? **Y/N**

Do you eat or drink to satisfy your emotions? **Y/N**

PHYSICAL

What is your exercise/activity level? Low/ Moderate/ High

What types of exercise do you like to do?

How often do you exercise and for how long?

How many minutes per day do you spend outside? _____

CARDIOVASCULAR

High Blood Pressure ___ Chest Pain ___ Irregular Heartbeat ___
Blood clots ___ Swelling of Hands/Feet ___ Difficulty in Breathing ___
Dizziness ___ Fainting ___ Low Blood Pressure ___
Cold Hands/Feet ___ Heart attack/surgery? Y/N If so, when: _____

RESPIRATORY

Breathing Difficulty ___ Production of Phlegm ___ Cough ___ Bronchitis ___
Coughing Blood ___ Pneumonia ___ Asthma ___
Other _____

GYNECOLOGY

Doctor/ OB/GYN: _____

Age: 1st Menses ___ # of Pregnancies ___ Heavy Periods ___ Irregular Periods ___
Painful Periods ___ Sores ___ Breast Lumps ___ Fibroids ___ Clots ___
Miscarriages ___ Premature Births ___ Birth Control Pill ___ Breast Implants ___
Sexually Transmitted Diseases: _____
Type Of Birth Control: _____ For how long? _____.
Last Mammogram: _____ Do you do monthly self breast exams? Y/N
Sex drive: Poor/ Good / Great

Are there any other health issues you would like to discuss? Please comment.

Are you aware that most Alternative therapies may not be covered by your insurance company? Y/N If so, are you willing to pay out of pocket? Y/N

Client Authorization

**Please understand that as the director and owner of Alternative Health Associates, I am not a Medical doctor, I am a Naturopathic doctor. AHA Integrated Wellness does have MD on staff. As an ND, I do not I prescribe pharmaceutical drugs, nor do I provide medical diagnosis or surgery. I do use homeopathic medicines, herbs and supplements.*

I do provide preventive well care and natural health care with natural cures, assessments, tests, education and nutritional counseling. I do continue to maintain a dental hygiene license, and am a Board Certified Orofacial Myologist. Also, I am a Board Certified Alternative Naturopathic Doctor through the Alternative Medical Association and Drugless Practioner Association. The Naturopathic philosophy is to do no harm, work on prevention, work on the root of the problem, and work on the whole person. It will be important that you are involved with your healthcare and health choices. It is important that you continue to communicate with all your doctors during your treatments. Naturopathic doctors are complementary to other health providers. I agree and give Alternative Health Associates my permission to release any information or/reports to other healthcare professionals in regards to my care.

I have read the statement above and understand completely:

Client to sign and date:

Emergency contact person and phone #:

Dr. Gail Kopin ND – Alternative Health Associates

Individual and Corporate Wellness

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American Alternative Medical Association/ Board Certification # 60202604

American Association of Drugless Practioners/Board Certification # 72862604

International Association of Orofacial Myology/Board Certification # 114-C-97

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American Naturopathic Medical Association

