Dr. Thomas J. Francescott

info@drfrancescott.com

Date:_____

Patient Health Profile

This form is confidential. This information cannot and will not be given to anyone outside this clinic without your written permission.

Please answer all questions honestly and with the intent of providing as thorough a picture as possible of your health history.

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, emotionally, and spiritually.

The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires. *Your time, thoughtfulness and honesty are greatly appreciated!*

Name:_____ Sex: M F SS#:_____

Race or ethnic background:_____

Date of birth:_____ Age: _____Blood Type:_____ Ht_____ Wt_____

Address:_____

City:_____ State:_____Zip:_____

Phone: Home:_____Cell: _____Work:_____

Email Address:_____ Website:_____

Occupation_____Hours per week_____ Retired_____

Employer_____

Person to notify in case of emergency: _____Phone:_____

Who can we thank for referring you?_____

Has any other family member already been a patient at the clinic? _____

____Married ____Partnership ____Separated ____Divorced ____Widowed ____Single

Live with: _____Spouse _____Partner ____Parents ____Children ____Friends ____Alone

Do you have any children? Yes No How many? _____ Their names/ages:_____

_____

What other health care practitioners are you currently seeing?_____

_____

_____

Have you ever consulted a Naturopathic Physician before? Yes No

Who?_____

Date of last complete physical exam: _____ Date of last blood tests: _____

For women: Date of last Pap Smear: _____ Results: normal abnormal don't know

Are you willing to change your living habits to improve your health? Yes No

What goals do you have for your visit today?_____

_____

_____

Please list up to 8 major health concerns in order of their importance:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

How did these conditions develop? Are there traumatic events that you can identify as having caused or clearly aggravated your health problems. What happened in your life around this time? *If you prefer, list these in order of occurrence on a separate page.*

_____

_____

_____

MEDICATIONS: List all the drugs(prescription/non-prescription) including dosages.

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Are you allergic to any drugs, foods, chemicals, animals, environmental substances? ☐ Yes ☐ No

If yes, please list:_____

What happens when you have an "allergy attack"? _____

What prior types of allergy testing have you had?: ☐ None ☐ Blood IgG/IgE food/inhalant

☐ Electroacupuncture ☐ Kinesiology("muscle testing") ☐ Food Intolerance testing ☐ Scratch

CURRENT SUPPLEMENTS: List all vitamins, minerals, herbs, homeopathics, with dosages

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

For doctors use only:

_____

_____

PAST MEDICAL HISTORY

Your Prenatal/birth/feeding history:

Any known problems/birth trauma during your mother's pregnancy with you:_____

_____

C-section?_____ Umbilical cord problems?_____ forceps used?_____ Antibiotics?_____

Breast fed?_____ how long?_____ Formula (kind):_____how long?_____

Age solid foods began:_____ What foods were eaten in your first year of life?_____

_____

What childhood illnesses have you had?

☐ Rubella (German 3 day measles)	☐ Measles (2 week)	☐ Mumps	☐ Chickenpox
☐ Whooping Cough	☐ Polio	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Roseola	☐ Asthma	☐ Thrush	☐ Epilepsy
☐ Mononucleosis	☐ Strep Throat	☐ Ear infections	☐ Colic
☐ Rashes/cradle cap	☐ Constipation	☐ Jaundice	☐ Headaches

HOSPITALIZATIONS:_____

SURGERIES (with dates)**:** _____

X-rays, CAT scans, Mammograms, or other studies you have had:_____

_____

Major accidents/traumas (with dates):_____

Severe stresses/emotional traumas:_____

Immunizations: ___Polio ___Tetanus ___Measles/Mumps/Rubella ___Pertussis ___Diptheria

___Hepatitis B ___chicken pox ___H. influenzae ___Flu shot ___Other for travel_____

FAMILY HISTORY: (*Please list ages and if deceased, what they passed from and at what age)*

Mother's Side	Father's Side
Grandfather_____	Grandfather_____
Grandmother_____	Grandmother_____
Mother_____	Father_____

Your Sisters _____

Your Brothers _____

_____

Has any BLOOD RELATIVE had any of the following:

☐ Anemia	☐ Hay Fever	☐ Kidney Disease
☐ Arthritis	☐ Heart Attack	☐ Mental Illness
☐ Asthma/hayfever	☐ High Blood Pressure	☐ Alzheimers
☐ Bleeding (easily)	☐ Seizure/Epilepsy	☐ Alcoholism
☐ Cancer	☐ Sickle Cell Anemia	☐ Obesity
☐ Diabetes	☐ High Cholesterol	☐ Osteoporosis
☐ Epilepsy	☐ Thyroid (hyper/hypo)	☐ Liver Disease
☐ Eczema	☐ Tuberculosis (TB)	☐ Stroke
☐ Glaucoma	☐ Venereal Disease	☐ Autoimmune Disease

LIFESTYLE:

Do you drink alcohol? ☐ Yes ☐ No How often?: wine_____beer_____other alcohol_____
Do you use tobacco or have you in the past? ☐ No ☐ Yes, how long? _____ how much daily?_____
Do you now or have you in the past used recreational drugs? ☐ Yes ☐ No _____
Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins? ☐ Yes ☐ No
If yes, please explain_____

_____
Do you exercise? ☐ Yes ☐ No What form(s)?_____
How often?_____
Do you make time for rest, relaxation or meditation during the day and/or before bed? ☐ Yes ☐ No
How often? _____How do you relax?_____
What are your interests or hobbies?_____
Which of the following do you do regularly: ☐ Jogging ☐ Swimming ☐ Walking ☐ Biking ☐ Gardening
☐ Yoga ☐ Breathing Exercises ☐ Meditation ☐ Weightlifting ☐ Pilates ☐ Pray
☐ Other activities:_____
Do you use regularly? ☐ Electric Hair dryer ☐ Electric Blanket ☐ Heating pad ☐ Cosmetics, Perfumes
Are your home and/or work environments well ventilated? ☐ Yes ☐ No Mold? ☐ Yes ☐ No
Are there unusual/unpleasant smells in your work/living environment? ☐ Yes ☐ No
When were the ducts in your home last cleaned?_____

DIET:

How many meals do you generally eat each day? ☐ One ☐ Two ☐ Three ☐ More than three
Do you: ___eat out often ___diet frequently ___skip meals frequently
Do you have any special diet or eating restrictions? ☐ Yes ☐ No if yes, please explain_____

_____
List the primary foods you include in your diet?_____
List the foods you exclude from your diet_____
Mark which of these you consume regularly. ☐ Coffee ☐ Caffeinated teas ☐ Artificial sweeteners
☐ Processed foods ☐ Preservatives ☐ Refined foods ☐ Margarine ☐ Trans-fatty acids ☐ Sugar/sweets
List any other foods you eat which you suspect may be harmful to your health_____
List any foods you crave, regardless of their nutritional value (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.)_____
List any foods to which you have a bad reaction:_____
Are you thirsty often? ☐ Yes ☐ No at night? ☐ Yes ☐ No How much water do you drink daily?_____
What temperature do you prefer to drink? ☐ Hot ☐ Cold ☐ Room Temp.
Are you satisfied with your diet as it is now? ☐ Yes ☐ No If no, why not?_____

_____
SLEEP: Do you have trouble falling asleep? ☐ Yes ☐ No If yes, what keeps you up?_____

_____
Do you wake at night and can't fall back to sleep? ☐ Yes ☐ No_____
Do you wake feeling refreshed? ☐ Yes ☐ No_____
Do you have recurring dreams? ☐ Yes ☐ No If yes, what is the theme?_____

_____
What position do you sleep in?_____
For Doctor use only:_____

_____

_____

PERSONAL:

Are you happy in your job or career? ☐ Yes ☐ No _____

_____

What personal goals do you have?_____

What makes you happy?_____

What are you grateful for?_____

What is your individual & unique purpose in this life?_____

Religious/spiritual affiliation_____

What would you like to change most about your life?_____

_____

What behaviors, habits, or thoughts would you like to eliminate?_____

_____

Is your present sex life satisfactory? _____

General Status:

Listed below are factors which may or may not influence your state of being. Please check the appropriate box of ONLY those with SIGNIFICANT influence on your health.

BETTER	WORSE		BETTER	WORSE	
☐	☐	Winter	☐	☐	Spring
☐	☐	Summer	☐	☐	Autumn
☐	☐	Cold	☐	☐	Heat
☐	☐	Dampness or dryness	☐	☐	Storms
☐	☐	Sun	☐	☐	Wind
☐	☐	Open air (being outside)	☐	☐	Confined (stuffy) air
☐	☐	Change of weather	☐	☐	Moonlight
☐	☐	Ocean seashore	☐	☐	Mountains
☐	☐	Physical exertion	☐	☐	Upon rising
☐	☐	Morning	☐	☐	Afternoon
☐	☐	Evening	☐	☐	Night
☐	☐	Bath	☐	☐	Warm application
☐	☐	Cold application	☐	☐	Traveling
☐	☐	Before menstruation	☐	☐	During menstruation
☐	☐	After menstruation	☐	☐	Having the windows open

For Doctor use only:

_____

_____

_____

_____

_____

_____

_____

PLEASE CHECK IF YOU HAVE NOW OR HAVE HAD IN THE PAST, ANY OF THESE SYMPTOMS*

Skin/hair/nails

NOW/PAST (please circle any applicable in this section)

_____ _____ Skin-rough, dry, scaly, bumpy, itching
_____ _____ Rashes, warts, moles, cysts
_____ _____ Acne/Pimples, hives, athletes foot, eczema, psoriasis, skin infections
_____ _____ Nails: Color changes, ridges, pits, weak or brittle, white spots on nails
_____ _____ Hair loss, coarse hair, hair thinning, hair growth on face or body(females only)
_____ _____ Herpes, shingles, brown spots or bronzing of skin
_____ _____ Cuts heal slowly, bruise easily, peeling of skin on feet
_____ _____ Painful lymph nodes, swollen glands, difficulty stopping bleeding

For doctor use only:_____

Endocrine

NOW/ PAST		NOW/ PAST	
_____	_____ Unexplained weight loss/gain	_____	_____ Cold hands or feet
_____	_____ Prefers hot weather	_____	_____ Chronic fatigue
_____	_____ Prefers cold weather	_____	_____ Weakness
_____	_____ Can't stand cold	_____	_____ Increased thirst
_____	_____ Can't stand heat	_____	_____ Increased hunger

Head

NOW/ PAST		NOW/ PAST	
_____	_____ Dizziness	_____	_____ Double vision
_____	_____ Severe headaches(sinus, tension)	_____	_____ Fainting spells
_____	_____ Seizures, convulsions	_____	_____ Migraines

Eyes

NOW/ PAST		NOW/ PAST	
_____	_____ Poor eyesight (near or far-sighted)	_____	_____ Glaucoma
_____	_____ Light hurts eyes	_____	_____ Eyes bulging
_____	_____ Eye dryness, eyes itchy	_____	_____ Double vision

Ears

NOW/ PAST		NOW/ PAST	
_____	_____ Discharge from ears	_____	_____ Pain in ears
_____	_____ Hearing loss	_____	_____ Ringing in ears
_____	_____ Sensitivity to noise	_____	_____ Ear infections

Nose

NOW/ PAST		NOW/ PAST	
_____	_____ Nose bleeds frequent	_____	_____ Loss of smell
_____	_____ Sinus congestion	_____	_____ Nasal scabs/crusts
_____	_____ Nasal polyps	_____	_____ Deviated septum

Mouth

NOW/ PAST		NOW/ PAST	
_____	_____ Sore mouth or tongue	_____	_____ Loss of teeth
_____	_____ Speech difficulties	_____	_____ Cold sores, blisters
_____	_____ Bleeding gums	_____	_____ Tooth pain

Mouth continued For doctors use only:_____

NOW/ PAST

_____ _____ Grinds teeth at night
_____ _____ Reduced sense of taste or smell

NOW/ PAST

_____ _____ Jaw pain, jaw clicks
_____ _____ Dental work (a lot)

Throat

NOW/ PAST

_____ _____ Persistent hoarseness
_____ _____ Difficulty swallowing
_____ _____ Recurrent strep throat
_____ _____ Feeling of constriction or "lump"

NOW/ PAST

_____ _____ Loss of voice
_____ _____ Pain
_____ _____ Chronic sore throat
_____ _____ Swollen tonsils/glands

Neck

NOW/ PAST

_____ _____ Stiffness
_____ _____ Pain (describe area/type)

NOW/ PAST

_____ _____ Injuries
_____ _____ Swelling

Respiratory

NOW/ PAST

_____ _____ Unexplained fever
_____ _____ Chest pain when breathing
_____ _____ Wheezing/Asthma
_____ _____ Difficulty breathing
_____ _____ Chest congestion

NOW/ PAST

_____ _____ Sinusitis
_____ _____ Bronchitis
_____ _____ Shortness of breath
_____ _____ Daily cough
_____ _____ Sigh frequently

Cardiovascular

NOW/ PAST

_____ _____ Chest pain when walking
_____ _____ Chest pain when sit/lying
_____ _____ Ankle or abdominal swelling
_____ _____ Heart palpitations
_____ _____ Chest tightness
_____ _____ Heaviness in arms/legs

NOW/ PAST

_____ _____ Leg vein problems
_____ _____ Leg pain when walking
_____ _____ Numbness/tingling in extremities
_____ _____ Heart murmur type:_____
_____ _____ Stroke
_____ _____ High altitude discomfort

Gastrointestinal

NOW/ PAST

_____ _____ Constipation
_____ _____ Diarrhea
_____ _____ Alternating constipation & diarrhea
_____ _____ Change in bowel movements
_____ _____ Hemorrhoids
_____ _____ Black stools
_____ _____ Blood in stools
_____ _____ Stools - yellow, grey, green, foul
_____ _____ Frequency of bowel movements
_____ _____Loss of appetite

NOW/ PAST

_____ _____ Indigestion immediately after a meal.
_____ _____ Indigestion 2-3 hours after meals with fullness, bloating or pain.
_____ _____ Stomach aches
_____ _____ Symptoms worse with stress & tension
_____ _____ Heavy, full feeling after eating
_____ _____ Mucous in stool
_____ _____ Undigested food in stool
_____ _____ Appetite change: increase or decrease
_____ _____ Date of last test for blood in stool

_____ _____ Insatiable appetite
_____ _____ Vomiting blood
_____ _____ Frequent/severe nausea
_____ _____ Excessive belching
_____ _____ Excessive lower bowel gas
_____ _____ Abdominal bloat/distension
_____ _____ Distress from fat or greasy foods
_____ _____ Bad breath(halitosis)
_____ _____ Body odor (including feet)
_____ _____ Liver problems/pain

_____ _____Weight change: increase or decrease
_____ _____Heartburn or ulcers
_____ _____Bitter/metallic taste in mouth
_____ _____Compulsive eating
_____ _____Addictive eating
_____ _____Parasites
_____ _____Sickness from foreign travel
_____ _____Coated tongue
_____ _____Itchiness in anus/rectum
_____ _____Gallbladder stones/attacks

Urinary tract

NOW/ PAST

_____ _____ Frequent urination
_____ _____ Night urination
_____ _____ Difficulty holding urine
_____ _____ Bladder infections
_____ _____ Strong odor to urine

NOW/ PAST

_____ _____Painful(burning) urination
_____ _____Difficult starting urine
_____ _____Blood in urine
_____ _____Urinary tract infections
_____ _____Unusual color to urine

Male Reproductive

NOW/ PAST

_____ _____ Prostate problems
_____ _____ Swelling, lumps, pain in testicles
_____ _____ Discharge from penis
_____ _____ Infertility
_____ _____ Venereal disease

NOW/ PAST

_____ _____Painful erection
_____ _____Difficult achieving/maintaining erection
_____ _____Difficulty or premature ejaculation
_____ _____Sex drive reduced
_____ _____Urine stream not as forceful

Female Reproductive

NOW/ PAST

_____ _____ Lumps in breast(s)
_____ _____ Nipple discharge
_____ _____ Breast pain
_____ _____ Pelvic pain
_____ _____ Abnormal vaginal discharge
_____ _____ Vaginal itching/burning
_____ _____ Genital eruptions
_____ _____ Yeast infections frequent
_____ _____ Endometriosis
_____ _____ Hysterectomy

NOW/ PAST

_____ _____Painful sex
_____ _____Lack of sexual desire
_____ _____Difficulty feeling sexual arousal
_____ _____Never/seldom have orgasms
_____ _____Menstruation excessive
_____ _____Menstruation absent
_____ _____Bleed/spot between periods
_____ _____Infertility
_____ _____Hot flashes, vaginal dryness
_____ _____Fibroids/cysts

Have you ever used birth control pills? ☐ Yes ☐ No If yes, how long_____
_____

Have you ever used an **I.U.D.**? ☐ Yes ☐ No How long?_____ What kind?_____
Age of first menstruation _____ Did you have a normal puberty? ☐ Yes ☐ No_____
Periods occur every _____ days. Regular? ☐ Yes ☐ No Periods usually last _____ days (average).
Date of last period_____
_____ # of pregnancies _____ # of births _____ # of miscarriages _____ #of abortions

*(Please mark **B** if before, **D** if during or **A** if after menstruation for any below)*

PMS-A ('Anxiety')	**PMS-D ('Depression')**	**PMS-C ('Craving')**	**PMS-H ('Hyperhydration')**
_____ Nervous tension	_____ Depression	_____ Headache	_____ Weight gain
_____ Irritability	_____ Forgetful	_____ Craving for sweets	_____ Bloating
_____ Mood changes	_____ Crying	_____ Increased appetite	_____ Extremity swelling
_____ Anxiety	_____ Confusion	_____ Heart pounding	_____ Breast tenderness
_____ Insomnia	_____ Dizziness or fainting		

Pituitary

NOW/ PAST		**NOW/ PAST**	
_____	_____ Failing memory	_____	_____Intestinal bloating
_____	_____ Low blood pressure	_____	_____Abnormal thirst
_____	_____ Increase sex desire	_____	_____Decreased sex desire
_____	_____ Splitting headaches	_____	_____Chunky hips or waist
_____	_____ Menstrual disorders	_____	_____Ulcers, colitis
_____	_____ Low sugar intolerance	_____	_____High sugar tolerance

Thyroid

NOW/ PAST		**NOW/ PAST**	
_____	_____ Overweight	_____	_____Decrease appetite
_____	_____ Difficulty losing weight	_____	_____Nervousness
_____	_____ Constipation	_____	_____Heart palpitations
_____	_____ Tired upon rising	_____	_____Irritable/restless
_____	_____ Easily fatigued	_____	_____Increased appetite
_____	_____ Dry or scaly skin	_____	_____Underweight
_____	_____ Chilly/sensitive to cold	_____	_____Flush/get hot easily
_____	_____ Mental slowness	_____	_____Insomnia
_____	_____ Hair loss, hair coarse	_____	_____Intolerant to high temperature

Adrenals

NOW/ PAST		**NOW/ PAST**	
_____	_____ Easily stressed	_____	_____Nails weak, ridged
_____	_____ Easily/chronically fatigue	_____	_____Tendency to get hives
_____	_____ Dizziness on standing	_____	_____Rheumatism/arthritis
_____	_____ Headaches	_____	_____Perspire easily
_____	_____ Hot flashes	_____	_____Low blood pressure
_____	_____ Bronzing of the skin	_____	_____Weak after getting a cold
_____	_____ Craves salt	_____	_____Facial hair (women)

Neurological

NOW/ PAST		**NOW/ PAST**	
_____	_____ Loss of balance/fainting	_____	_____Paralysis
_____	_____ Dizziness regularly	_____	_____Numbness/tingling (circle)
_____	_____ Convulsions (seizures)	_____	_____Temporary loss of sensation
_____	_____ Tremor (shaking, trembling)	_____	_____Lack of strength
_____	_____ Blurred/double vision	_____	_____Memory loss

Musculoskeletal

NOW/	PAST		NOW/	PAST	
_____	_____	Joint pain/stiffness	_____	_____	Muscle cramps
_____	_____	Arthritis	_____	_____	Stiffness in morning
_____	_____	Backaches	_____	_____	Sciatica
_____	_____	Bone pain	_____	_____	Scoliosis
_____	_____	Heel spurs	_____	_____	Referred pain down legs or arms
_____	_____	Herniated disc	_____	_____	Jaw pain

Emotional

NOW/	PAST		NOW/	PAST	
_____	_____	Anxiety	_____	_____	Fears/phobias
_____	_____	Restlessness	_____	_____	Mental confusion
_____	_____	Excessive worry	_____	_____	Decreased concentration, comprehension
_____	_____	Depression	_____	_____	Obsessive thoughts
_____	_____	Despair/Discontent	_____	_____	Shy, timid
_____	_____	Suicidal thoughts	_____	_____	Critical of self
_____	_____	Suicide attempts	_____	_____	Critical of others
_____	_____	Loneliness/feel alone	_____	_____	Lack self-confidence
_____	_____	Mood swings	_____	_____	Suspicious/jealous
_____	_____	Prefer to be with company	_____	_____	Sensitive to noises
_____	_____	Prefer to be left alone	_____	_____	Extremely neat/clean
_____	_____	Afraid when left alone	_____	_____	Post traumatic stress syndrome
_____	_____	Would rather be left alone when not feeling well	_____	_____	Anger feelings
			_____	_____	Claustrophobia

Blood Sugar issues

NOW/	PAST		NOW/	PAST	
_____	_____	Eat when nervous	_____	_____	Get shaky if meal missed
_____	_____	Excessive appetite	_____	_____	Crave sweets/coffee
_____	_____	Loss of Appetite	_____	_____	Lightheaded if miss meal
_____	_____	Hungry between meals	_____	_____	Overeating sweets upsets
_____	_____	Irritable if meals skipped	_____	_____	Low blood sugar
_____	_____	Fatigue relieved by eating	_____	_____	Awaken a few hours after sleeping

Thank you very much. I look forward to assisting you in your healing process.