



- 9925 SW Nimbus Ave, Suite 100, Beaverton, OR 97008
- 3015 NE 62nd Ave, Portland, OR 97213

Health History Questionnaire

Date _____ Referred By _____

Patient Information

Patient's Name _____		
Last Name	First Name	Middle Initial
Street Address _____		
City _____	State _____	Zip Code _____
Home Phone _____	Work Phone _____	
Birth Date _____	E-mail: _____	
Single Married Widowed Divorced	Sex M / F	Age _____
Occupation: _____	Full-time	Part-time
Emergency contact: _____	Relationship _____	
Home: _____	Work: _____	Mobile: _____

<p>Five Main Health Concerns:</p> <p>1. _____ Date of onset: _____</p> <p>2. _____ Date of onset: _____</p> <p>3. _____ Date of onset: _____</p> <p>4. _____ Date of onset: _____</p> <p>5. _____ Date of onset: _____</p>	<p>Other Health Issues:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Having reviewed the Menu of Services offered, check the boxes indicating your level of interest:

Office Visit: Health Consultation Preventive Lab Review Detoxification

Bioenergetic Level: Nutrition Response Testing Body Restoration Technique

Physical Medicine: Bowen Therapy Microcurrent Korean Hand Therapy

Holistic Programs: The Wellness Program Seasonal Core Support

Allergies:

Diseases that run in your Family:

Type of treatment you are currently receiving:

MEDICATION LIST

Please list the medications you are currently taking, include non-prescription drugs.

Medication & Dose	Reason	Effectiveness	Side Effects

SUPPLEMENT (vitamins & herbs) LIST

List all vitamins, minerals and other nutritional supplements.

Supplement/Dose	Reason	Supplement/Dose	Reason

What is your weight: _____ What is your ideal weight: _____

The Whole Person:

The harmonious functioning of all areas of the individual is essential to health. Using the 0 to 10 scale below, please rate yourself in the various categories of life at the present time. Zero means you have nothing developed in this area and Ten indicates a high level of achievement or satisfaction.

Physical/Health

0	1	2	3	4	5	6	7	8	9	10
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Mental/Attitude

0	1	2	3	4	5	6	7	8	9	10
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Emotional Status

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Family/Relationships

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Friends/Social

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Living Environment

0	1	2	3	4	5	6	7	8	9	10
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Rest & Recreation

0	1	2	3	4	5	6	7	8	9	10
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Career

0	1	2	3	4	5	6	7	8	9	10
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Financial/Money

0	1	2	3	4	5	6	7	8	9	10
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Spiritual/Personal Growth

0	1	2	3	4	5	6	7	8	9	10
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Typical Example of your Diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (include amount) _____

Are you vegetarian or vegan? Y / N

List your food/dietary restrictions: _____

List diets you have tried the past year: _____

<p>Number of bowel movements per day: _____</p> <p>What time of the day are you most tired: _____</p> <p>Number of hours sleep you are getting: _____</p> <p>Time you go to sleep: _____ Time you wake up: _____</p>

Is there any other pertinent medical information I should know about (ex: history of cancer, major surgeries or organ removal/excision)? (Please list)

IF your symptoms have been ongoing, it may require a period of time in uncovering the cause of your health condition. What is your level of commitment in addressing the your areas of concerns at this time?

Minimal		Some						Committed		
0	1	2	3	4	5	6	7	8	9	10

<p>What are constraints/obstacles that you foresee sabotaging therapeutic protocols that may be given to you? (Please List)</p>	<p>What are the positives lifestyle habits you are currently engaged in that are supportive of your health goals? (Please List)</p>

What expectations do you have from your first visit with me?

PRIVACY

You can leave messages pertaining to my health at

- my home number my office number Other _____

You can leave messages including business name and time **only** at

- my home number my office number Other _____

Do **NOT** leave a message at my home number my office number

Thank you for taking the time to fill out this lengthy questionnaire.
Also fill out the Metabolic Assessment Form.
It will be a valuable tool in assessing your health care needs.

Consent to Treat

I have been informed and understand that:

- 1) Any treatment or advice provided to me as a patient of Harold J. Maderazo, ND is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.
- 2) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.
- 3) No physician, student, instructor, employee, agent or anyone else under the direction or control of the clinic is recommending that I refrain from seeking or following the advice of another licensed health care provider.
- 4) The treatment and therapies provided or recommended by this clinic may be different from those usually offered by another licensed health care provider.
- 5) I, the undersigned, understand that Harold J. Maderazo, ND is not an employee or agent of Euro Institute/DH Wellness Center but is providing naturopathic services at these facilities as an Independent contractor. Euro Institute/DH Wellness Center assumes no liability for any services rendered to the clients by Dr. Harold Maderazo.
- 6) Payment is due in full at the time of your visit by one of our accepted forms of payment.

Signature

Date