H.E.R.O. 英雄 Fitness

Name_____
Date_____
Address
_____
City_____State_____Zipcode_____
Phone(mobile)_____(hm)_____(wk)_____
E-mail_____
Age_____Date of birth_____
Gender female male
Place of birth _____
Employer_____
Past Occupations_____
Married Partnership Single Separated Divorced Widowed
Live with: Spouse or partner Parents Children Friends Pet(s) Alone
Next of kin or other to reach in case of emergency
_____
Relationship_____ Phone_____
How did you hear about my services?
_____

I hope you will answer the questions on this medical history form as thoughtfully as possible. Many of the questions that follow may not seem directly related to your main complaint or reason for seeking care. However, the answers to these questions, as well as the information you provide, will determine the individualized approach I take to begin your treatment.

Current Health Care Team:
Primary Care Physician: _____
Office Number: _____
Specialist Physician: _____Specialty: _____
Office Number: _____
Specialist Physician: _____Specialty: _____
Office Number: _____

Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):
Practitioner Name: _____
Office Number: _____

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Practitioner Name: _____
Office Number: _____
Have you been treated by a Naturopathic Doctor? _____
Name: _____ Number: _____
Name:_____ Number: _____
Primary Health Concerns: *Please list you primary health concerns in order of importance.*

Concern	Onset	Frequency	Severity
Ex: Headache	*June 1992*	*4 times/week*	*mild/mod/severe*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

What types of therapies have you tried?
___Diet modification ___Fasting ___Herbs ___Vitamins/minerals ___Homeopathy
___Chiropractic ___Acupuncture ___Conventional drugs ___Other

Please list any operations/surgical procedures/blood transfusions/major injuries (with dates):
_____
_____
_____
_____
Immunizations/vaccinations:
_____
Date of last Physical Exam: _____Date of last Blood Tests: _____

What would you rate your overall energy level at? (1-10, 10 being highest) _____
Do you wake-up feeling refreshed? Y__ if N__ , give details.
_____
How many glasses of water do you drink per day?
Tap_____ Filtered_____ Distilled_____ Reverse Osmosis_____ Spring_____
Alkalized_____ Other_____
How many glasses of soda pop_____ juice_____ or milk_____ do you drink per day?
How many cups/day do you drink of the following?

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Coffee_____ Black tea _____ Herbal/Green tea _____
Do you add milk/cream/sugar _____
Do you smoke? Y / N # of cigarettes/ cigars/pipes day:_____ How many years?_____
In the past? _____
Do you drink alcohol? N__ Y__ # of drinks and type of drinks per week: _____
Do you use recreational drugs? N__ Y__ Type_____
Frequency_____
In the past? _____
Do you watch TV? N__ Y__ Number of hours per week:_____
Do you exercise? N__ Y__ Hours per week:_____
Types of exercise:
_____
Please list any life threatening allergies:
_____
Other allergies, sensitivities, or intolerances (e.g. food, medication, environmental, chemical, etc.):
_____
_____

What are the major stressors in your life? Do you consider severity of stress low, moderate or high?
_____
_____
What are your interests/hobbies?
_____

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What do you love to do that gives you a sense of satisfaction?
0=no fulfillment/10=great fulfillment

Career	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Health	1	2	3	4	5	6	7	8	9	10
Significant Other/Romance	1	2	3	4	5	6	7	8	9	10
Fun & Recreation	1	2	3	4	5	6	7	8	9	10
Family and Friends	1	2	3	4	5	6	7	8	9	10
Friends	1	2	3	4	5	6	7	8	9	10
Physical	1	2	3	4	5	6	7	8	9	10
Environment	1	2	3	4	5	6	7	8	9	10

I have indicated all of my known medical conditions above. I will alert the practitioner to any changes in my health status. It is my choice to receive naturopathic care.

Signature: _____

Printed:_____

Date: _____

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MEDICAL HISTORY

Check all that apply to you. Please specify the date of diagnosis where applicable:

HEAD
____ Glaucoma
____ Dental Problems
____ Migraines
____ Head injury
____ Eruptions
____ Sensitive scalp
____ Feeling of heaviness
____ Dandruff

RESPIRATORY
____ Asthma
____ Bronchitis
____ Emphysema
____ Pneumonia
____ Tuberculosis
____ Chronic cough
____ Spitting up mucus or blood
____ Wheezing
____ Pleurisy

GASTRO-INTESTINAL
____ Colitis/Chron's
____ Celiac Disease
____ Reflux
____ Inflammatory Bowel Disorder
____ Hepatitis
____ Gallbladder Disorders
____ Diverticulitis
____ Indigestion
____ Bloody stool
____ Light colored stool
____ Rectal pain
____ Rectal itching
____ Worse when missed a meal
____ Hemorrhoids
____ Marked thirst
____ Thirstless
____ Appetite increase/decrease
____ Hurried eating
____ Loss of taste
____ Difficulty swallowing
____ Ulcer
____ Bowel movements every day

CARDIOVASCULAR
____ High Blood Pressure
____ Cholesterol, Elevated
____ Heart Disease
____ Arrhythmia
____ Circulatory Problems
____ Clotting Disorder
____ Heart Attack
____ Stroke
____ Ankle or leg swelling
____ Rheumatic fever
____ Leg pain unrelated to injury
____ Easily bruising or bleeding
____ Phlebitis

NEUROLOGIC
____ Alzheimer Disease
____ Epilepsy

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_____ Parkinson's
_____ Multiple Sclerosis
_____ Restless Legs Syndrome
_____ Seizures
_____ Muscle weakness
_____ Vertigo/dizziness
_____ Paralysis
_____ Numbness or tingling
_____ Easily stressed

GENITOURINARY
_____ Kidney or Bladder Disease
_____ Painful urination
_____ Difficult urination
_____ Frequent urination
_____ Frequent infections
_____ Strong smelling urine
_____ Inability to hold urine
_____ Blood in urine
_____ Involuntary urination
_____ Frequently at night
_____ Prostate disease
_____ Discharge or sores

MUSCULOSKELETAL
_____ Carpel Tunnel Syndrome
_____ Gout
_____ Osteoporosis
_____ Rheumatoid Arthritis
_____ Osteoarthritis
_____ Pain
_____ Stiffness
_____ Swelling
_____ Numbness
_____ Tightness
_____ Burning
_____ Coldness
_____ Twitching
_____ Tremors
_____ Weakness
_____ Shooting pains

SKIN
_____ Easy Bruising
_____ Eczema
_____ Psoriasis
_____ Varicose Veins
_____ Allergies/Hay Fever
_____ Boils
_____ Color changes
_____ Lumps
_____ Warts
_____ Cysts
_____ Infections
_____ Swollen glands
_____ Pustules

ENDOCRINE
_____ Chronic Fatigue Syndrome
_____ Diabetes
_____ Thyroid Disorder
_____ Obesity
_____ Seasonal Affective Disorder
_____ Insomnia
_____ Hypo/hyperglycemia
_____ Excessive thirst
_____ Heat/cold intolerance
_____ Excessive hunger
_____ Excessive sweating
_____ Night Sweats
_____ Strong odor from perspiration

MENTAL/EMOTIONAL/ OTHER

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_____ Depression
_____ Anxiety
_____ Drug Addiction
_____ Eating Disorder
_____ Learning Disability
_____ Alcoholism

BLOOD, IMMUNE, INFECTIONS

_____ High stress/tension
_____ Mental mistakes (dyslexia, forgetfulness, etc.)
_____ Hallucinations/ hearing voices
_____ Attempted/Considered suicide
_____ Fears, phobias
_____ Treatment for other issues
_____ ADD/ADHD

CANCER

Type Date Diagnosed

_____ _____
_____ _____

MALE REPRODUCTIVE

_____ Enlarged Prostate
_____ Prostate Cancer
_____ Decreased Sex Drive
_____ Infertility
_____ Sexually Transmitted Disease

Type Date Diagnosed

_____ _____
_____ _____

Other _____

Date of last prostate exam

_____

_____ Autoimmune Disease
_____ Lyme Disease
_____ HIV
_____ Anemia
_____ Chronically swollen glands
_____ Reactions to vaccinations
_____ Chronic infections
_____ Slow wound healing

FEMALE REPRODUCTIVE

_____ Menstrual irregularities
_____ Endometriosis
_____ Fibrocystic breasts
_____ Fibroids/ovarian cysts
_____ PCOS
_____ Premenstrual Syndrome (PMS)
_____ Menopausal Symptoms
_____ Breast Cancer
_____ Vaginal infections
_____ Decreased sex drive
_____ Urinary Tract Infection
_____ Bleeding between cycles
_____ Abnormal PAPS

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____ Cervical Dysplasia
____ Sexual difficulties
____ Vaginal dryness
____ Vaginal itching
____ Swelling or lumps on breasts
____ Nipple discharge
____ Painful intercourse

____ Difficulty conceiving
____ Sexually Transmitted Diseases
Type Date Diagnosed
_____ _____
_____ _____
Other _____

WOMEN ONLY
Date of last menstrual
cycle: _____
Length of cycle: _____ days
Interval of time between cycles:
_____ days
Date of last GYN exam:
_____
PAP + / -- Date: _____
Form of Birth Control:
_____
# of children: _____
# of pregnancies: _____

# of miscarriages: _____
# of abortions: _____
Are you pregnant? Y N
Age of first menses: _____
Age of last menses (if menopausal):
_____

List any PMS symptoms (e.g.
heavy/scanty flow, clots,
cramping, breast tenderness,
bloating, mood changes, other):
_____
_____

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FAMILY HISTORY
(M/Mother, F/Father,
B/Brother, S/Sister,
FP/Father's Parents,
MP/Mother's parents)
____ Alzheimer's Disease
____ Cancer - please specify
type(s):
_____
_____
____ Crohn's Disease
____ Diabetes
____ Drug abuse
____ Epilepsy, seizures
____ Hearing Loss
____ Heart Disease
____ HIV
____ High Blood Pressure
____ Kidney Disease
____ Liver Disease
____ Nervous or Mental
Disorder
____ Migraine Headaches
____ Neurological Disorders
____ Obesity
____ Osteoporosis
____ Rheumatoid Arthritis
____ Thyroid Disorder
____ Other:
_____

YOUR HEALTH HABITS

Today's Weight _____ lb
Height _____ ft _____ in

NUTRITION & DIET
____ Mixed Food Diet (animal
and vegetable)
____ Vegetarian
____ Vegan
____ Organic Food
____ Salt Restriction
____ Fat Restriction
____ Starch/ carbohydrate
restriction
____ Calorie Restriction
Please list any Food
Restrictions:
(eg. dairy, gluten, soy, etc.)
_____
_____

FOOD FREQUENCY

(# of times per day or week)
Fruits _____
Vegetables _____
Whole Grains _____
Beans, nuts, legumes _____
Dairy _____
Fish _____
Meat, poultry _____
Eggs _____

B L D
Eat _____# of meals/day
____ Graze (small frequent meals)
____ Generally eat on the run
____ Eat constantly whether hungry or not

SLEEP
Hours per night: _____
Sleep quality:
____ Poor
____ Fair
____ Good

EATING HABITS
Skip meals – list which one(s):

Rate each of the following symptoms based on how you've been feeling for the: Past 2 weeks
Point Scale
0 — Never or almost never have the symptoms
1— Occasionally have it; effect is not severe
2 — Occasionally have it; effect is severe
3 — Frequently have it; effect is not severe
4 — Frequently have it; effect is severe

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ Pain/Neuralgia
_____ Acne
_____ Twitching
_____ Excessive Sweating
_____ Discoloration
Total _____

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred, spots or tunnel vision (does not include near- or farsightedness)
_____ Impaired vision
_____ Color Blind
_____ Double vision
_____ Aversion to sun
_____ Sensation of 'sand in eye'
_____ Cataracts
_____ Eye pain
_____ Glasses or contacts

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_____ Sties
Total _____

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
Total _____

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ Frequent colds
_____ Breathing problems
_____ Eruptions, sores
_____ Nose bleeds
_____ Loss of smell
Total _____

Mouth/ Throat/ Neck
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, or lips
_____ Canker sores, fever blisters
_____ Tooth sensitivity
_____ Teeth grinding
_____ Peculiar taste
_____ Copious saliva
_____ Jaw clicking, TMJ
_____ Cracked lips
_____ Cracked tongue
_____ Chronic bad breath
_____ Lumps
_____ Goiter
_____ Swollen glands
_____ Pain or soreness
_____ Choking feeling
Total _____

Skin
_____ Body acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
Total _____

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
Total _____

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____Chest pain
Total _____

Digestive Track
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn

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_____ Intestinal/stomach pain
Total _____

Joints
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total _____

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Emotions
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
Total ____

Other Issues
_____
_____

Total _____

Energy Level
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
Total _____

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total _____

Grand Total _____

Context of Care Overview

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1. Why did you choose to come see me?

_____

2. What do you know about my approach?

_____

3. What results do you expect to have achieved by the end of this meeting?

_____

4. What long term expectations do you have from working with me?

_____

5. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle?
(Rate from 0 to 10, 10 being 100% committed)
1 2 3 4 5 6 7 8 9 10

6. What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

_____

_____

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive** lifestyle habits?

_____

_____

8. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which you will be learning?

_____

9. What is currently lacking from your life right now?

_____

10. What do you feel is in abundance in your life right now?

_____

11. Is there anything else you want to share- OR would prefer we don't discuss?

_____

_____

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Please list any vitamins, minerals, herbal supplements, homeopathics, over-the-counter and prescribed medications and creams that you are taking.

NAME: _____ DATE: _____

SUPPLEMENT	MANUFACTURER	FORM	DOSAGE	FREQUENCY
EXAMPLE: VITAMIN C	PERQUE	powder	1500 mg= ½ tsp	½ tsp 2 times/day

MEDICATION	FORM	DOSAGE	FREQUENCY	DATE STARTED

Describe any history of drug reaction/allergy: _____

_____

OTHER COMMENTS:

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Please be advised of the fees effective January 1, 2017

Dr. James Bach, DNH,DN
NASM PES, CES, CPT

Initial Visit (1.25-1.5 hrs)- $225
Follow-Up Visit 1 hr- $155
Follow-Up Visit 30 minutes- $80

Packages of 5 Appointments:
1 hr- $725
30 minutes- $375

All Payments Must Be Made In Advance
Cash-Check (Payable to H.E.R.O. Fitness)-VENMO- Money Order

All Appointments Carry A 24 Hour Notification Policy For Cancelling Or Rescheduling.
Notification Inside Of 24 Hours Will Result In Forfeiture Of The Appointment.