Art Mueller, N.D.

Naturopathic Health Questionnaire

Date ____/____/______
MM DD YYYY

Patient Name ______________________________ **Address** ______________________________

Birth Date ____/____/______ **Tel #** (___) ___-_____ ______________________________
MM DD YYYY

Medication/ Drugs: 1) ______________________ 2) ______________________ 3) ______________________

Supplements Currently Taken: 1) ______________________ 2) ______________________ 3) ______________________

1. Bowel Related	**Yes**	**No**	
Excess Bloating, Belching	___	___	
Acid Reflux, Heartburn	___	___	
Either Constipation/Diarrhea	___	___	BM?__/__
Get Side Pain w Fatty Meals	___	___	
IBS or Crohn's, Colitis, Div.	___	___	
Poor Digestion/ Meats?	___	___	
Blood, Hemorrhoids	___	___	

2. Allergy Related	**Yes**	**No**
Skin: Eczema, Psoriasis, Acne	___	___
Hayfever, Pollen	___	___

Food Allergies ______________________________
____

3. Immune System	**Yes**	**No**	
Fibromyalgia, Chronic Fatigue	___	___	
Sinus Infect Plugged Nasal drip	___	___	
Autoim: MS, Lupus, Sceroderm.	___	___	______
Colds, flu up to 3 times/yr.	___	___	
Ear Infections, Strep Throat	___	___	

4. Heart Related	**Yes**	**No**	
Palpitations, Murmur	___	___	
High Blood Pressure	___	___	___/___
High Cholesterol	___	___	______
Swollen Ankles or feet	___	___	
Vertigo, Tinnitis	___	___	

5. Lung Related	**Yes**	**No**
Short of Breath (smoke?)	___	___
Asthma, Puffers	___	___
Pneumonia, Bronchitis	___	___
Angina, Stroke	___	___

6. Physical/Structural	**Yes**	**No**
Arthritis, Gout, Joints	___	___
Fingers/Toes	___	___
Back/Sciatica	___	___
Neck/Whiplash	___	___
Bone Dens, Osteopor/penia	___	___

7. Anxiety, Depression	**Yes**	**No**
Anxiety, Panic Attacks	___	___
SAD, Depression	___	___
Stress Level 1-10	___	___
PMS Related	___	___

8. Urine	**Yes**	**No**
Kidney Stones	___	___
Urinary Infections, Yeast	___	___

9. General	**Yes**	**No**
Diabetes	___	___
Root Canals	___	___
Mouth Ulcers, Cankers	___	___
Rheumatic, Scarlet Fever	___	___
Leg Cramps, Restless Legs	___	___
Warts; Cold Sores	___	___
+Cold Hands or Feet	___	___
+Low Energy	___	___
+Dry Skin, Hair Loss	___	___
+ On thyroid Meds?	___	___
Nail Ridges	___	___
Varicose Veins	___	___
Iron/B12 Deficiency	___	___
Raynaud's Syndrome	___	___

10. Female/Male (optional)	**Yes**	**No**
Fibroids, Endometriosis	___	___
PMS Crmp, Anx, Dep, Migr	___	___
BCP (used to help)	___	___
Menop, HRT (now or past)	___	___
Hot Flashes	___	___
Prostate, BPH, Pee night	___	___
Low Libido	___	___

11. Head Related	**Yes**	**No**
Hearing, Sight Problems	___	___
Macular Degen., Glaucoma	___	___
Migraines, H/A	___	___
Insomnia: Falling Asleep?	___	___

12. Family: Hypertension ____ Diabetes _____ Cancer ____ Cholest ____ Other ______________________

13. Exercise: ____