

**SOULITUDES Wellness Center Dr. Bonnie Chudyk, ND, RN**  
1387 Fairport Rd. Bldg 500 Suite 520 Fairport, NY 14450 585-377-1990

All medical records are kept private and confidential in compliance with US Government Patient Privacy Laws. They will not be released to anyone or agency without your signed permission.

**Client Health History**

**Date** \_\_\_\_\_

Informed Consent: Please read and initial. Do not proceed with this questionnaire if you decline to accept. 📄 **I'm here as a new patient.** I give my permission to proceed with naturopathic care including evaluation, assessment, recommendations, and follow-up care. I fully understand that my care here is not a guarantee of treatment success or cure, implied or otherwise, and/or that it will result in any improvements in your medical condition or general health. Initials \_\_\_\_\_

Client Name \_\_\_\_\_ Date of birth \_\_\_\_\_ M / F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Day phone # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Mobile phone # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Emergency contact \_\_\_\_\_ Relation \_\_\_\_\_

1. Name(s) of primary care provider (PCP) \_\_\_\_\_.
2. Were you referred? Y / N
3. Are you currently receiving medical treatment for the same health problems you are here for? Y / N
4. Are you currently a patient of another naturopath or alternative care provider? Y / N  
If yes, who \_\_\_\_\_
5. Have you ever been a patient of a naturopathic physician or alternative care provider? Y / N
6. List any concerns you about your current medical treatment? \_\_\_\_\_
7. Have you discontinued or refused any medical treatment, surgery and / or medication against the advice or knowledge of your physician within the past 12 months? Y / N If yes, what & why?  
\_\_\_\_\_
8. Are you here to possibly change or reduce your need for certain prescription drugs or avoid surgery? Y / N
9. Do desire your care here to be \_\_\_ supportive and complimentary to your current medical care or \_\_\_replace it?

\* Please note: Discontinuing any prescribed treatment or medication is entirely a decision that is made between the patient and the prescribing doctor.

**Reason For Visit**

In a few words or sentence list the most important health problem(s) you want evaluated? Use the back if needed. Put an x by the number if you are currently receiving medical treatment for it. Put an  by the number if you had previously been treated for it.

- 📄 1. \_\_\_\_\_
- 📄 2. \_\_\_\_\_
- 📄 3. \_\_\_\_\_
- 📄 4. \_\_\_\_\_
- 📄 5. \_\_\_\_\_
- 📄 6. \_\_\_\_\_

Are you currently in treatment for mental health disorder, anger management, or alcohol, drug or substance abuse? Y / N If yes, circle which one.

Client Name \_\_\_\_\_

Date \_\_\_\_\_

**Current Medications:**

List all prescription medications (Rx) you are now taking. List name, strength & dosage schedule.

- 1. \_\_\_\_\_ # \_\_\_\_\_ 6 \_\_\_\_\_ # \_\_\_\_\_
- 2. \_\_\_\_\_ # \_\_\_\_\_ 7 \_\_\_\_\_ # \_\_\_\_\_
- 3. \_\_\_\_\_ # \_\_\_\_\_ 8 \_\_\_\_\_ # \_\_\_\_\_
- 4. \_\_\_\_\_ # \_\_\_\_\_ 9 \_\_\_\_\_ # \_\_\_\_\_
- 5. \_\_\_\_\_ # \_\_\_\_\_ 10 \_\_\_\_\_ # \_\_\_\_\_

How many times have you been prescribed antibiotics in the last 12 months? 0, 1, 2, 3, 4 or more

List all **non-prescription, over the counter (OTC) drugs** you are currently taking:

Do you frequently skip or forget to take any medications on time? Y / N

**Current Nutritional Supplements:**

Prepare a separate list if you need more space. Include strength and amounts.

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_
- 7. \_\_\_\_\_ 8. \_\_\_\_\_
- 9. \_\_\_\_\_ 10. \_\_\_\_\_

Are any of your nutritional supplements being prescribed as part of a medical treatment? Y / N

Are you in the habit of taking supplements: once daily \_\_\_ 2 X daily \_\_\_ 3 X daily \_\_\_

**Previous Surgery**

List from most recent and include month / year performed.

- 1. \_\_\_\_\_ mo/yr \_\_\_\_\_ 3. \_\_\_\_\_ mo/yr \_\_\_\_\_
- 2. \_\_\_\_\_ mo/yr \_\_\_\_\_ 4. \_\_\_\_\_ mo/yr \_\_\_\_\_
- 3. Are under the care of a doctor for recent post surgical recovery? Y/N Scheduled for new surgery? Y / N  
If yes, describe: \_\_\_\_\_
- 4. List any health problems you have refused surgery for: \_\_\_\_\_

**Previous Accidents & Injuries**

- 1. \_\_\_\_\_ mo/yr \_\_\_\_\_ 2. \_\_\_\_\_ mo/yr \_\_\_\_\_

**Allergic History**

List all known allergies and/or sensitivities (list inhalants, foods, chemicals, drugs, etc):

Any life threatening allergic reactions that required emergency care? Y / N

Client Name \_\_\_\_\_

Date \_\_\_\_\_

For each past condition, check all the boxes corresponding to yourself and each family member.

\* When listing siblings, indicate which one by number--e.g. sister number 2 (if more than one brother or sister).

(M)=mother's side (F)=father's side

Condition:	Self	Mother	Father	Brother(s)	Sister(s)	GM(M)	GF(M)	GM(F)	GF(F)
Alzheimer's									
Depression									
Anxiety									
Diabetes									
Migraine									
Osteoarthritis									
Rheumatoid arthritis									
Fibromyalgia									
Chronic Fatigue Syndrome									
Asthma									
Hayfever or Hives									
Eczema									
Psoriasis									
Obesity									
Heart disease									
Heart attack									
Hypertension									
High cholesterol									
Stroke									
Digestive disorders									
Gout									
Kidney disorder									
ADHD									
Cancer (type)									

**Personal Health Habits:**

Do you exercise regularly? Y / N Frequency: daily several times weekly once weekly occasionally

What exercise activity do you usually engage in? \_\_\_\_\_

Do you smoke? Y / N Former smoker? Y / N How long have you been a non-smoker? \_\_\_\_\_

Avg. number of alcoholic beverages per day? 0 less than 1 1-2 3 or more

Do you smoke marijuana regularly? Y / N

Do you believe that your health problem may be related to high stress / burnout? Y / N

**Client Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Health & Symptom Survey** Highlight, circle, underline or fill in the blank where appropriate

**GENERAL** Current Wt. \_\_\_\_\_ Ht. \_\_\_\_\_ maximum Wt. \_\_\_\_\_ recent weight gain recent weight loss

**SKIN / NAILS** acne rosacea boils itchy scaly oily dandruff eczema psoriasis rash bruise easy ulceration slow wound healing infection sores growths mole changes nail fungus brittle nails Other \_\_\_\_\_

**HEAD** headaches: daily \_\_\_ weekly \_\_\_ migraine cluster tension headaches recent head injury

**EYES** burning itching watery redness infection poor night vision cataract glaucoma macular degeneration eye lid crusting / oozing blurred vision double vision

**EARS** hearing loss earache fluid in ears ringing dizziness vertigo infection wax

**TEETH & GUMS** mo / yr last teeth cleaning \_\_\_\_\_ Do you floss? Y / N dentures gums bleed easily cavities bad breath broken or missing teeth broken fillings coated tongue difficulty chewing

**NOSE / SINUS** hayfever / allergies sneezing sinus infections stuffiness runny / drippy loss of smell nose bleeds burning discharge: white yellow-green clear

**NECK / THROAT** frequent sore throat hoarseness clears throat often swollen tonsils or adenoids swollen glands pain goiter difficulty swallowing food difficulty swallowing pills

**RESPIRATORY** cough wheezing frequent chest colds/flu bronchitis asthma emphysema chest discomfort congestion sputum: yellow-green, bloody, clear short of breath .... lying or w/ exertion

Other EENT symptoms: \_\_\_\_\_

**HEART / CIRCULATION** chest pain angina palpitations irregular heartbeat rapid heartbeat hypertension murmur history of rheumatic fever ankles swelling bruise easily varicose veins

cold hands / feet swelling or fluid retention leg pain or cramps....w/ exercise, w/o exercise, at night Other symptoms: \_\_\_\_\_

**DIGESTION** heartburn / indigestion acid reflux nausea burning / gnawing pain ulcer burping bloating gas fullness irritable bowel syndrome constipation diarrhea colitis inflammatory bowel disease

diverticulosis candida diverticulitis hiatal hernia hemorrhoids itching anus dairy/lactose intolerance colon polyps blood in stool Other symptoms: \_\_\_\_\_

**NERVOUS SYSTEM & MISC.** burning feet tremor unsteady walking numbness or tingling

muscle weakness night sweats MS Parkinson's Other specific neurological disorder or symptoms: \_\_\_\_\_

**GENITO-URINARY** frequent urination dribbling or reduced urine flow frequent bladder infections  
burning Incontinence: fecal / urinary itching / redness rash / sores discharge blood in urine kidney stone /  
infection STD history: herpes gonorrhea syphilis chlamydia cervical warts (HPV) HIV / AIDS

Other symptoms: \_\_\_\_\_

(**optional**) Sexual preference: heterosexual homosexual bisexual sexually active: Y / N

**MEN ONLY** impotence erectile dysfunction loss of libido hernia testicle: pain, swelling or  
lumps prostate enlargement PSA test, mo/yr \_\_\_\_\_ PSA level \_\_\_\_ prostate exam, mo/yr \_\_\_\_\_

Other symptoms: \_\_\_\_\_

**WOMEN ONLY** # of pregnancies \_\_\_\_ # of births \_\_\_\_ Are you pregnant Y / N birth control pill Y / N

Dates of last: PAP \_\_\_\_\_ Normal results? Y / N mammogram \_\_\_\_\_ Normal results? Y / N

Name of Women's Care Practitioner: \_\_\_\_\_

Other: \_\_\_\_\_ Menstrual cycle history, premenopausal women:  
regular / irregular cycle occurs every \_\_\_\_ days periods last \_\_\_\_ days

Dates of last period: started \_\_\_\_\_ stopped \_\_\_\_\_ flow: light, medium, heavy spotting between period

uterine fibroids endometriosis Poly cystic ovary (PCO) Other symptoms: \_\_\_\_\_

**PMS Symptoms:** (increase in intensity starting 7-14 days before your period (luteal phase) and subsides with  
onset of period.) mood swings irritability anger bloating cramps breast tenderness confusion  
depression acne fluid retention

**Menopausal Symptoms:** hot flashes mood swings night sweats vaginal dryness weight gain at menopause

**Breasts:** pain swelling tenderness nipple discharge or retraction lumps / cysts rash

**Vaginal:** foul odor itching burning dryness yeast discharge bleeding sores painful intercourse

Other symptoms: \_\_\_\_\_

**MUSCLES / JOINTS** joint pain stiffness swollen joints hot/red joints muscle tenderness

muscle cramps / spasm muscle weakness bursitis tendonitis scoliosis

Joint pain areas: neck upper back lower back hips knees shoulder elbow hands/wrists ankles/ feet

Muscle pain areas: neck shoulder upper arms forearm thigh calves buttocks upper back lower back

Other symptoms: \_\_\_\_\_

**MENTAL / EMOTIONAL** chronic daily fatigue low energy depression anxiety / nervousness

irritable weeping & crying jags high stress panic attacks mood swings poor memory

confusion cloudy / foggy anorexia / bulimia agoraphobia paranoia / schizophrenia restless sleep

insomnia suicidal thoughts

Other symptoms: