HEALTH HISTORY QUESTIONNAIRE

Dr. Caileen Vermilyea ND

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

This form is extensive, in order to investigate and understand your physical, mental, and emotional health. The nature of your response to the following questions will go a long way in assisting my understanding of your health and journey to wellness. **Please return at least 24 hours prior to first appointment.**

Date of Initial Visit: ________________________

PERSONAL INFORMATION

<table>
<tr><td colspan="4">First Name: MI: Last Name:</td></tr>
<tr><td>Date of Birth:</td><td>Age:</td><td>Gender:</td><td></td></tr>
<tr><td colspan="4">Street Address:</td></tr>
<tr><td colspan="4">City: State: Zip:</td></tr>
<tr><td colspan="2">Preferred Phone (circle one: home, work, cell):</td><td colspan="2">Is it okay to leave messages on this phone?
Yes No</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Emergency Contact: Relationship: Phone:</td></tr>
</table>

HEALTH HISTORY

<table>
<tr><td colspan="2">What are your most important health concerns? List in order of importance:</td></tr>
<tr><td colspan="2">What have you been seen for/ treated for in the past? Please include approximate dates and by whom.</td></tr>
<tr><td colspan="2">Please list any surgeries or hospital stays you have had and approx. dates:</td></tr>
<tr><td>Do you have a Primary Care Provider?
Yes No</td><td>If yes, please provide name & phone number:</td></tr>
<tr><td colspan="2">Please list other providers/specialist involved in your care (Name & Phone): include OBGYN and Dental</td></tr>
</table>

When was your last physical exam?	When did you last have blood work? *
When was your last OBGYN workup (if applicable):	When was your last dental checkup:
Blood type: Not Known A B AB O RH+ RH -	Current Height: ________ Current Weight: ________ Maximum weight and when: ________
Please indicate the type of care you are seeking: Full Naturopathic consultation Yoga Therapy Cranio-sacral Therapy and Advanced Body work	Lifestyle and Dietary Support Botanical Medicine and/or Homeopathy

ALLERGIES

Do you have any medication allergies or any allergic reactions to anything?	Yes	No
If **YES** please indicate type of reaction and severity:		

MEDICATIONS & SUPPLEMENTS

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications (including Oral contraceptives if applicable), vitamins, minerals, herbs and homeopathic remedies.

Name of meds/supplements	**Dose**	**Directions**
(such as Synthroid, Vitamin D, etc.)	(45mg, etc)	(such as 1 tablet twice a day, etc.)

Please check box to indicate if *you or a family member* has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition, if applicable such as mother (M), father (F), sibling (S) or maternal or paternal grandmother/grandfather (MGM, MGF, PGM, or PGF).

Condition	Self	Relative	Condition	Self	Relative

Alcohol/Drug Issue			Head trauma		
Allergies			HIV/AIDs		
Anemia			Infectious illness		
Anxiety			Irritable Bowel Syndrome		
Autoimmune dx			Irritable Bowel Disease		
Arthritis			Kidney Disease		
Asthma			Meningitis		
Bruising easily			Mental illness		
Birth trauma			Menstrual pain or irregularity		
Blood Transfusion			Nerve/Muscle Disease		
Cancer			Neurodegenerative issue		
Cataracts			Osteoporosis		
Chronic Fatigue			Reproductive Issues		
Chronic Respiratory dx			Seizures/epilepsy		
Clotting Disorder			Skin issues; Eczema/ psoriasis, etc		
Depression			Sexually transmitted dx		
Diabetes			Stroke		
GERD			Thyroid Dysfunction		
Glaucoma			Tuberculosis		
Hepatitis			Ulcers		
High blood pressure			Other:		
Heart Disease			Other:		
Headaches			Other:		

HEALING EXPLORATION

What behaviors or lifestyle habits do you currently engage in regularly that you believe support health?
What behaviors or lifestyle habits do you currently engage in regularly that you believe are not supportive to your health?
What, if anything, would you like to improve in regarding your mental health?
What, if anything, would you like to improve in regard to your physical health?
What, if anything, would you like to improve in regard to your emotional health?

What, if anything, would you like to improve in regard to your spiritual health?
When in your life did you feel the healthiest and most fulfilled? Paint a picture.
What are your passions/ drives/ goals?
Three words that describe yourself:

***Please submit, with this form, a copy of any blood work you have received in the last 2 years (or longer if pertinent to condition)**

INFORMED CONSENT FOR TREATMENT

Name___________________________________ Date of Birth_____________________________

I hereby authorize Dr. Caileen Vermilyea, ND to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **Common diagnostic procedures**: e.g., urinalysis, venipuncture, pap smears, laboratory, order imaging
- **Physical Exams:** full physical exams, including gynecological if necessary
- **Minor office procedures**: e.g., dressing a wound, cleansing.
- **Medicinal use of nutrition**: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
- **Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, glycerites, capsules, tablets, creams, salves, or plasters
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

- **Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction ,balancing of work and social activities.
- **Psychological Counseling**
- **Physical Medicine:** naturopathic osseous manipulation and soft tissue work, including CranioSacral Therapy
- **Prescription medications:** natural and synthetic hormones, advisory as necessary. Although trained in pharmaceuticals, NDs in California may can not legally prescribe or dispense Schedule I-II, as well as Schedule III-V in most cases, unless under the authorization of MD/DO.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: all interventions carry potential risks, including but not limited to: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures, possible interaction between natural supplements or products prescribed and prescription drugs.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Consent: With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Caileen Vermilyea ND regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Dr. Caileen Vermilyea ND.

____________________________ ______________________________________
Signature of Patient Signature of Patient Representative or Guardian

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Date