Julianne M. Forbes, ND, LLC
133 Brooks Edge Farm Rd.
Westbrook, ME 04092
207-310-0829

Client History

Client Data:

Name _____ Date _____
Address _____ Age _____ Date of Birth _____
City _____ State _____ Zip Code _____ Sex F M
Telephone # (home) _____ (work) _____
May we leave messages concerning your visit on your answering machine at home phone? _____
Occupation _____ Hours per week _____
Who can we call if we are unable to reach you? _____Phone _____
EMAIL: _____ (name) (relationship)

History of condition:

When and where did you last receive medical or health care? _____
What was the reason? _____
When was your last blood test? _____ What kind? _____
What are your most important health problems? (list in order of importance)

1. _____
2. _____
3. _____
4. _____
5. _____

How long has your main problem been bothering you? _____
When was the first time you noticed this condition? _____
What do you suspect is causing your problem or contributing to it ? _____
What treatment approaches have you tried? _____
_____
Have you seen a naturopath before? _____ What was the therapy and the results? _____
_____
Are you currently working with a Doctor of conventional medicine ? (M.D.____ or D.O._____)
List diagnoses _____

Family History: Please list ages, health problems and if deceased, the cause of death.

	Mother	Father	Brothers	Sisters	Child	Grandparents (mom's)/(dad's)
Age if living	_____	_____	_____	_____	_____	_____
Health (G=good,P=poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____

Tuberculosis _____ _____ _____ _____ _____ _____
Age at death/ cause _____ _____ _____ _____ _____ _____

***Family History** continued:*
What is your nationality?_____
Do you have any blood relatives (aunt, uncle, grandparent) who has had:
_____ allergies _____ arthritis _____ skin disease _____depression _____ heart attack _____ ulcers
_____ genetic problems _____ thyroid problems _____ seizures _____ sickle cells

Health History:
The general state of your health is? (excellent ___), (good ____), (average ____), (fair ____), (poor ____)
Childhood Illnesses: _____ Scarlet Fever _____Diphtheria _____ Rheumatic fever _____ Polio
(y=yes,n=no) _____ Mumps _____ Measles _____ German Measles _____ Mono
_____ Smallpox _____ Chickenpox _____ Whooping cough

Immunizations: _____ Polio _____ Tetanus Shot(not anti-toxin) _____ Pertussis _____
(y=yes,n=no) _____ Measles/Mumps/Rubella _____ Diphtheria. Negative Reaction to any?_____

Hospitalizations and Surgery: _____
_____
_____
X-rays and special studies (CAT scan, MRI) you have had: _____
_____
_____
Please list any abnormal lab results (include when and if you re-tested with a normal result)_____
_____
Current Medications: _____ laxative _____ cortisone _____ pain relievers _____ antacids
_____ sleeping pills _____ thyroid medication _____ tranquilizers
_____ MAO inhibitor _____appetite suppressants
_____ Calcium Channel Blocker _____ Diuretic _____ Birth Control Pills

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking (give full name, dosage and how long you have been taking it, write on back if you need more space):

Prescription/Over the counter: _____
_____
_____
_____

Vitamins/Herbs:_____
_____

Which of the following do you currently use:
_____ tobacco, packs per day = _____ _____alcohol, X per week = _____
_____ coffee, cups per day = _____ _____ soda, X per day = _____
_____ artificial sweetner, X per day _____
Describe any exercise you currently do and frequency:
_____
_____
Do you eat three meals a day? _____
Do you sleep well? _____ Number of hours per night _____ Wake rested? _____
Do you enjoy your work? _____ Does anything you do at work make your condition worse?_____
_____
What are your main interests and hobbies?_____

Review of Systems:

General: Weight _____ Weight 1 year ago _____ Maximum weight _____ Height _____

Describe your energy level (poor, ok, great) _____, is this a change in the last 6 months?

Circle Y (yes) a condition you have now , P (past) a condition you have had before, and N (never) had.

Skin:				*Respiratory:*			
Warts	Y	P	N	Constriction	Y	P	N
Rashes:	Y	P	N	Cough:	Y	P	N
Eczema:	Y	P	N	Sputum:	Y	P	N
Acne, boils:	Y	P	N	Spit up blood:	Y	P	N
Itching:	Y	P	N	Wheezing:	Y	P	N
Color Change:	Y	P	N	Asthma:	Y	P	N
Lumps:	Y	P	N	Bronchitis:	Y	P	N
Night sweats:	Y	P	N	Pneumonia:	Y	P	N
Head:				Pleurisy:	Y	P	N
Headache:	Y	P	N	Emphysema:	Y	P	N
Head injury	Y	P	N	Difficulty breathing:	Y	P	N
Eyes:				Pain on breathing:	Y	P	N
Impaired vision:	Y	P	N	Shortness of breath:	Y	P	N
Glasses/contacts:	Y	P	N	at night?	Y	P	N
Eye pain:	Y	P	N	lying down?	Y	P	N
Tearing/dryness:	Y	P	N	Tuberculosis:	Y	P	N
Double vision:	Y	P	N	*Cardiovascular:*			
Glaucoma:	Y	P	N	Heart Disease:	Y	P	N
Cataracts:	Y	P	N	Angina:	Y	P	N
Ears:				High Blood Pressure:	Y	P	N
Impaired hearing:	Y	P	N	Murmurs:	Y	P	N
Ringing:	Y	P	N	Chest Pain:	Y	P	N
Earaches:	Y	P	N	Swelling in ankles:	Y	P	N
Dizziness:	Y	P	N	Palpitations:	Y	P	N
Nose/Sinuses:				*Gastrointestinal:*			
Frequent colds:	Y	P	N	Liver disease	Y	P	N
Nose bleeds	Y	P	N	Ulcer?	Y	P	N
Stuffiness:	Y	P	N	Heartburn:	Y	P	N
Hay fever:	Y	P	N	Change in thirst:	Y	P	N
Sinus problems:	Y	P	N	Change in appetite:	Y	P	N
Mouth/Throat:				Nausea:	Y	P	N
Frequent sore throat:	Y	P	N	Vomiting:	Y	P	N
Sore tongue:	Y	P	N	Vomit blood:	Y	P	N
Gum problems:	Y	P	N	Hemorrhoids:	Y	P	N
Hoarseness:	Y	P	N	Belching/gas:	Y	P	N
Dental cavities	Y	P	N	Blood in stool:	Y	P	N
Neck:				Gall bladder Disease:	Y	P	N
Lumps:	Y	P	N				
Swollen glands	Y	P	N				
Goiter:	Y	P	N				
Pain or stiffness:	Y	P	N				
Trouble Swallowing:	Y	P	N				

Bowel movement, how often: _____Is this a change: _____

Review of Systems: continued

Urinary:		*Musculoskeletal:*	
Pain on urination:	Y P N	Joint pain or stiffness:	Y P N
Increased frequency:	Y P N	Arthritis:	Y P N
Frequency at night:	Y P N	Broken bones:	Y P N
Inability to hold urine:	Y P N	Muscle spasms or cramps:	Y P N
Frequent infections:	Y P N	Weakness:	Y P N
Kidney stones:	Y P N	*Peripheral vascular:*	
Female reproductive:		Deep leg pain:	Y P N
Age menses began:	_____	Cold hands/feet:	Y P N
Average # of days long:	_____	Varicose veins:	Y P N
Total days in cycle:	_____	Thrombophlebitis:	Y P N
Bleeding between:	Y P N	*Neurologic:*	
Are cycles regular:	Y P N	Fainting:	Y P N
Pain during intercourse:	Y P N	Seizures:	Y P N
Painful menses:	Y P N	Paralysis:	Y P N
Excessive flow:	Y P N	Muscle weakness:	Y P N
Birth control:	Y P N	Numbness or tingling:	Y P N
Type:	_____	Loss of memory:	Y P N
# of pregnancies:	_____	*Emotional:*	
# of live births:	_____	Depression:	Y P N
# of miscarriages:	_____	Mood swings:	Y P N
# of abortions:	_____	Anxiety or nervousness:	Y P N
Difficulty conceiving:	Y P N	Tension:	Y P N
Menopausal symptoms:	Y P N	*Endocrine:*	
Sexually active:	Y P N	Hypothyroid:	Y P N
Venereal disease:	Y P N	Heat or cold intolerance:	Y P N
Age Menses Ceased	_____		
Breasts:		Excessive thirst:	Y P N
Do you do self exam:	Y P N	Excessive hunger:	Y P N
Lumps:	Y P N	Blood:	Y P N
Pain or tenderness:	Y P N	Anemia:	Y P N
Nipple discharge:	Y P N		
	Male reproductive:		
Hernias:	Y P N	Prostate disease:	Y P N
Venereal disease:	Y P N	Discharge or sores:	Y P N
Testicular masses:	Y P N	Testicular pain:	Y P N
Sexually active:	Y P N		

Health Choices:

Which of the following would you like included in your health plan if appropriate?

Vitamins _____ Minerals _____ Dietary supplementation _____

Homeopathy _____ Botanicals _____ Exercise _____

Hydrotherapy _____ Chinese Medicine theory _____

Dietary recommendations _____ Stress management _____

Other _____

What do you think is the most important part of your healing process? _____

_____

_____

In an effort to keep costs down we do not offer billing services or payment plans to patients or insurance companies. Payment for services and lab work is due in full upon completion of your visit. There are some insurance companies that cover naturopathic medicine. If you plan to submit your paid invoices to your insurance company I will be happy to provide you with insurance codes. Telephone calls to the doctor over five minutes will be charged at the office visit rate. A fee of $25.00 will be charged for a missed appointment or an appointment canceled without 24 hours notice. Should you need to cancel an appointment, please call the office and leave a message on the answering machine which records the date and time of your call.

I have read and understand the above policies: (signature)_____