

Healing Ways
Confidential Patient History

General Information:

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: (if different from above) _____

Telephone Numbers: Home: () _____ Work: () _____

E-mail _____

Patient's Occupation _____
__ Full Time __ Part Time __ School __ Retired __ Unemployed __ Other _____

Status: __ Single __ Married __ Divorced __ Widowed

Pets: _____

In Case of Emergency Notify: _____ Phone #: _____

Blood Type: _____

How did you hear about Healing Ways? __ Friend __ Phone Book __ Ad

Course/Seminar Taught by _____ Physician/Professional _____

Articles Written by or Referring To _____ Other _____

Financial Agreement:

I claim full financial responsibility for services rendered by Dr. Bärbel Aldridge and understand that payment is required in full at the time of service.

Signature-Patient or Parent of Minor _____

Current Health:

General: (Please check all that apply)

- Poor appetite Heavy appetite Hard to wake Poor sleep
- Light sleep Heavy sleep Insomnia Fatigue
- Tremors Vertigo Cold hands Cold Feet
- Hot Flashes Fevers Chills Sweat easily
- Localized weakness Poor coordination Change in appetite Cravings _____
- Peculiar tastes/smells Strong thirst (hot, cold drinks) _____
- Bleed or bruise easily (where) _____
- Sudden energy drop at _____ (times)
- How often do you eat? _____
- Do you have a reaction to missing meals? _____

What are your current health concerns? _____

If you have a specific condition, when did it first begin? _____

Has your condition been getting progressively worse? _____

Have you found anything that makes your condition better? _____

Have you found anything that makes your condition worse? _____

Exercise: _____ Relaxation: _____

Creative Outlet: _____

What are the stress factors in your life? _____

Are you currently under the care of a Medical Doctor or licensed health care professional? _____

If so, who? _____

Are you currently taking any medications or dietary supplements?
*** If yes, please complete the attached page: [Medications and Supplements]**

General Health: (Please check all that apply)

Habits:

- Cigarettes _____ per day Coffee ____ cups Caffeinated/day ____ Decaf/day
 Soda _____ cups/day Iced Tea _____ glasses/day Salt Sugar
 Water _____ glasses/day Drugs Alcohol

How many glasses of alcohol do you drink per day, week? (Include beer, wine, liquers and hard liquor)

Nutrition:

Please indicate your typical eating habits:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Misc.: _____

Additional Comments: _____

Family Medical History: (please check all that apply)

- Diabetes Cancer High Blood Pressure Heart Disease
 Strokes Seizures Asthma Allergies Alcoholism
 Other _____

If your parents or siblings have passed, what was the cause of death and at what age did it occur?

Your Past Medical History: (please include date)

Diagnosed illnesses:

- Cancer Diabetes High Blood Pressure Cardiovascular Disease
 Hepatitis
 Thyroid dysfunction Rheumatic Fever Seizures
 Environmental Toxicity _____
 Allergies: (Drugs, Chemicals, Foods) _____
 Other (explain) _____

Teeth:

- When was your last dental appointment? _____
Do you have any mercury/silver amalgam fillings? yes no
Do you have root canal fillings? yes no How many? _____
Removable bridge yes no
Fixed bridge
Implanted tooth
Periodontal (gum) disease yes no
Other _____

Surgeries: _____

Significant Trauma: (also accidents, falls, etc.) _____

Birth History:

- Prolonged labor forceps delivery Other _____

Occupational Stresses: (chemical, physical, psychological, etc.) _____

Skin and Hair

- Rashes Ulcerations Hives Itching Eczema
 Pimples Dandruff Loss of hair Change in hair/skin texture
 Other hair or skin problems _____
-

Head, Eyes Ears, Nose and Throat

- Dizziness Concussions Migraine Glasses Cataracts
 Eye Strain Eye Pain Poor Vision Night Blindness Color Blindness
 Blurry Vision Earaches Poor hearing Ringing in ears Nose Bleeds
 Mucus Dry Throat Dry Mouth Copious Saliva Sinus Problems
 Jaw Clicks Facial Pain Teeth Problems Grinding Teeth Sores - lips/tongue
 Headaches (where and when) _____
 Other head or neck problems _____
-

Cardiovascular:

- High Blood Pressure Low Blood Pressure Chest Pain Dizziness
 Irregular Heartbeat Cold Hands and Feet Fainting Phlebitis
 Difficult Breathing Swelling Hands/Feet Blood Clots
 Other _____
-

Respiratory:

- Cough Pneumonia Asthma Bronchitis Coughing Blood
 Tight Chest Difficulty breathing when lying down
 Production of phlegm (what color?) _____
 Other lung problems _____
-

Gastrointestinal:

- Nausea Vomiting Diarrhea Gas Bloating Heartburn
 Belching Black Stools Bad Breath Rectal Pain Hemorrhoids Constipation
 Bloody Stools Pain Cramps Sensitive Abdomen
 Laxative use (weekly) _____ Type _____
 Bowel movement (frequency) _____
 Other _____
-

Genito – Urinary:

- Painful Urination Frequent urination Blood in urine Urgency to urinate
 Kidney Stones Unable to hold urine Venereal Disease Impotency
 Wake up to urinate (How often) _____ Day Night
 Other G/U problems _____
-

Musculoskeletal:

- Neck Pain Muscle Pain Back Pain (where) _____
 Joint Pain (where) _____
 Other joint or bone problems _____
-

Neuropsychological:

- Seizures Poor Memory Anxiety Depression Easily Stressed
 Concussion Bad Temper Areas of Numbness Treated for emotional problems
 Considered/Attempted suicide
 Other neurological or psychological problems _____
-

Environmental Exposure

Have you used the following or had a situation where you might have been exposed to any of the following? :

- Pesticides Herbicides Fungicides X-rays (qty. ____)
 High Voltage lines Well water Orchards Fertilizer
 Insect sprays Glues Insulation New carpets Cleaning Solvents
 Industrial toxins Other _____
-

Pregnancy and Gynecology:

- Pregnancies Number births Premature Births Miscarriages
 Age at 1st menses _____
 Irregular Periods Clots Last PAP _____
 Last Menses Vaginal Sores Vaginal Discharge PMS symptoms
 Breast lumps Menopause Hysterectomy
 Birth Control (type and duration) _____
 Changes in body/ psyche prior to menstruation _____
-
- Heavy Flow Light Flow discomfort Long menses Short menses

Client: _____

Date: _____

Medication and Supplement Form

Name of Substance: _____

Why do you take it? _____

How long have you been taking this? _____

How often do you take this? At what times? _____

What, if any, effects have you noticed? _____

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