Confidential Patient History

Legal Name _____Name you preferred to be called _____

Address _____ City _____ State _____ Zip _____

Home (_____)_____ Work (_____)_____Mobile (_____)_____

Sex: Male ☐ Female ☐ Age _____ DOB _____ Social Security _____-_____-_____

Email _____

Name of Emergency Contact _____ Relationship _____

Best Number to Contact Them ☐ Mobile ☐ Home ☐ Work ☐ Other (_____) _____

How did you hear about Dr. Hamel?_____

Do you have health insurance? ☐ Yes ☐ No If you checked yes, please provide us with a copy of your insurance ID card(s).

Name of the insured_____ Insured's date of birth_____

What is their relationship to you? ☐ Spouse ☐ Child ☐ Other_____

Do they live at the same address as you? ☐ Yes ☐ No

If you checked no, what is their address_____City_____ State_____

Zip _____ Phone Number (_____) _____ Do you want to be added to Dr. Hamel's Newsletter? Y N

Nutritional, Metabolic & Structural Evaluation
Please complete the following information as completely as possible. This helps us to address your concerns and needs, and to build a health program personally designed for you.

Complaints | Please rank the child's health complaints and rate their severity (on a scale from 1-10, 10 being the worst).

_____
_____
_____
_____

Other Information | Please tell us any additional information or concerns about their health.

_____
_____
_____

Medical History | Please describe any conditions which are under the care of a physician.

Diagnosis _____
Date of onset _____ Duration of current symptoms _____
Doctor(s) involved, their specialty _____
How diagnosed (what tests)? _____
Current treatment (medication, etc.) _____
Treatment received in past, if any, and how it worked _____

Medications | Please list any medications you (the child) are taking, or have taken in the past, and for how long. State the reason for taking it.

_____
_____

Surgeries/Hospitalizations | What surgeries, operations, traumas, fractures, car accidents, etc. have you (the child) had?

(please list all with brief details such as date, outcome, etc.) _____
_____
_____

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Mother	Father	Brother	Sister	Onset	Outcome
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Arthritis (type)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Thyroid Imbalance	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____

Other _____

Review of Systems | Please check the " NOW " box for all conditions that you(the child) are now experiencing and mark the "PAST" box for any condition or symptoms experienced at any time in your life.

	N	P
General		
Weight loss	☐	☐
Weight gain	☐	☐
Head		
Headache	☐	☐
Dizziness	☐	☐
Head trauma	☐	☐
Fainting	☐	☐
Blacking out	☐	☐
Eyes		
Change in vision	☐	☐
Cataracts	☐	☐
Light sensitivity	☐	☐
Flashes in vision	☐	☐
Spots in vision	☐	☐
Mouth		
Bleeding gums	☐	☐
Cold sores	☐	☐
Dentures	☐	☐
Sore throat	☐	☐
Jaw pain	☐	☐
Changes in taste	☐	☐
Hoarseness		

	N	P
Nose		
Nosebleeds	☐	☐
Sinus problems	☐	☐
Lungs		
Difficulty breathing	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Persistent cough	☐	☐
Coughing phlegm	☐	☐
Coughing blood	☐	☐
Tuberculosis	☐	☐
Vascular		
Chest pain	☐	☐
Palpitations	☐	☐
Ankle swelling	☐	☐
Cold feet/hands	☐	☐
Leg cramps	☐	☐
Calf pain	☐	☐
Varicose veins	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐

	N	P
G-I System		
Gas	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Ulcers	☐	☐
Vomiting/Nausea	☐	☐
Abdominal Pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gall bladder disease	☐	☐
Liver disease	☐	☐
G-U System		
Difficulty urinating	☐	☐
Pain urinating	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Foul odor of urine	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Urinary infection	☐	☐
Genital infection	☐	☐

	N	P
Neurologic		
Seizures/Epilepsy	☐	☐
Strokes	☐	☐
Tingling sensation	☐	☐
Numbness	☐	☐
Weakness	☐	☐
Difficulty walking	☐	☐
Poor coordination	☐	☐
Muscle/Bone		
Joint pain	☐	☐
Stiffness	☐	☐
Muscle ache	☐	☐
Arthritis	☐	☐
Bone pain	☐	☐
Fractures	☐	☐
Dislocations	☐	☐
Skin		
Rash	☐	☐
Bruising	☐	☐
Brittle nails	☐	☐
Changes in moles	☐	☐
Itching	☐	☐
Peeling	☐	☐

	N	P
Conditions		
Hypertension	☐	☐
Diabetes	☐	☐
Thyroid condition	☐	☐
Heart condition	☐	☐
Rheumatic arthritis	☐	☐
Rheumatic fever	☐	☐
Glaucoma	☐	☐
Alcoholism	☐	☐
Cancer/Tumor	☐	☐
Polio	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Gout	☐	☐
Anemia	☐	☐
Osteoporosis	☐	☐
Osteoarthritis	☐	☐
High cholesterol	☐	☐
Migraines	☐	☐
TIAs	☐	☐
Headache unlike any previously experienced	☐	☐

Bowel Movements | Please circle those that apply.
How often: daily | more than once a day | skip days Consistency: normal | too hard | too soft | diarrhea alternating with hard
Amount: normal | too little Color: brown | black | yellow | whitish Other: mucus | foul smell | lots of gas
Comments:_____
Any Acid reflux? _____

Nutrition | Circle one.
Breastfed | Formula | Foods (describe): _____

Birth | Please circle those that apply.
Normal/vaginal | Forceps | Vacuum Extraction| Cesarean Section | Hematoma | Delayed (baby in birth canal for extended period) | Breech | Brow/Face Presentation | Shoulder Presentation | Erb's/ Klumpke's Palsy | broken clavicle

At Birth, any presence of: Jaundice, Meconium, Cyanosis??? Y N

Obstetrician/Midwife _____ Pediatrician _____

Milestones: Infant is able to (circle all that apply):
Respond to sound | Sit alone | Walk assisted | Says 5 or more words | Stands on one leg | Follow an object with his/her eyes | Crawl | Walk without assistance | Makes a tower of three objects | Walks on tiptoe | Holds head up | Stand | unintelligible babble | Copies a vertical line | Hops

Vaccinations | Has the child been vaccinated? Y N If yes, how old were they when they got them, and how many have they had?
_____
Are they on a delayed schedule? Y N How many more are left? _____Have they had any adverse reactions to any? Y N if yes, explain _____

Sleep | How many hours of sleep is the child getting? What is the quality of the sleep? Is the sleep schedule consistent? Please explain.

_____

Exercise | Is the child getting daily exercise? Y N Organized sports? Y N Explain _____
Is the child experiencing any stress? Y N Are they allowed time to relax and have fun? Y N Explain _____

Toxic Inventory / Personal Care Products | Please list any toxins, chemicals, or solvents you (child) have had exposure to or use of. These can include products for the yard, work, furniture, art, building/carpentry, etc. (list the brand names in the space provided):

☐ Shampoo _____	☐ Deodorant _____	☐ Toothpaste _____
☐ Body Soap _____	☐ Hand/Body Lotion _____	☐ Laundry Soap _____
☐ Dish Soap _____	☐ Household Cleaner _____	☐ Hairspray/Gel _____
☐ Nail Polish _____	☐ Hair Coloring _____	☐ Air Freshener _____
☐ Ant/Roach Spray _____	☐ Pesticides _____	☐ Other _____

Water/Hydration | How many glasses or bottles is the child drinking in an average day? ___ Do they drink tap water? ___
What brand(s) of drinking water do you use? _____
Do you cook with tap, bottled, or filtered water on a regular basis? _____
If you have a home water purifier, when was the last time you changed the cartridge? _____

Diets | Please check any applicable diet that you (the child) are currently on.

☐ Allergy rotation/desensitization	☐ No dairy	☐ Vegan	☐ Low fat	☐ Any other diet _____
	☐ Vegetarian	☐ Yeast-free	☐ Diabetic	
☐ Atkins/Zone diet	☐ Candida diet	☐ Low salt		

Signature_____ Date_____