Cougar Sound Spirits
Healing Center

77 Penacook Road
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(603) 927-4526 fax (603) 927-4101
Dr. Christine Kuhlman, ND, APRN
Dr. Amanda Hegnauer, ND

Date_____ Blood Type_____

Name_____

Date of birth_____

Present Health Care Concerns: In your opinion, what are your most important health care concerns in their order of significance? Please indicate the concern that motivated you to come in today.

1)_____

2)_____

3)_____

4)_____

Health History: Mark all the sections that apply.

Health as a child? _____ Good _____ Fair _____ Poor
Childhood Illnesses? _____ Scarlet Fever _____ German Measles _____ Measles _____ Pertusis _____Mononucleosis _____Polio _____Diabetes _____Rheumatic Fever _____ Chicken Pox _____ Diptheria _____ Mumps _____ Whooping Cough _____ Other _____
Were you breastfed as an infant? _____ Y _____ N
Hospitalizations (year and reason) _____
Surgeries (year and reason) _____
Serious Illness or injury (year and cause) _____
Vaccinations (year, type, adverse reaction?)
_____

Medications: Include all supplements, prescription and non-prescription drugs and indicate name, dosage, how often taken and for how long:
1)_____
2)_____
3)_____
4)_____
5)_____

Allergies: List any allergies you have to:
Drugs _____
Foods _____
Environmental _____
Animals _____
Other _____
What happens when you have an allergy attack? _____
_____

Habits: Substance use: For each please include approximate amount and for how long. If you have quit, please indicate past amount, duration of usage and when stopped.
Alcohol: _____Y _____ N _____ Tobacco: _____Y _____ N _____
Caffeine: _____ Y _____ N _____ Recreational Drugs: _____ Y _____ N _____
Diet: Any dietary restrictions or regimen? Describe _____
Are you satisfied with your diet now? Do you eat three meals a day? _____
Do you have any food cravings? What are they? _____
Do you sleep well? _____ Wake rested? _____ Average hours of sleep? _____
Enjoy your work? _____ Spend time outside? _____ How much time? _____
Exercise regularly? _____ What type of exercise? _____
How often? _____ How long? _____

Personal History: Currently (place a "C") or in the past (place a "P)
Abuse _____ Headaches _____ Skin Disease _____
Allergies _____ Heart Disease _____ Shortness of Breath _____
Arthritis _____ Hepatitis _____ Stomach/Intestinal Disorder _____
Back Injury _____ Hypertension _____ Tested Positive for HIV/AIDS _____
Chronic Constipation _____ Chronic Diarrhea _____Contemplated Suicide _____
Depression _____ Physical Trauma _____ Sexually transmitted Infection _____

For Women:
Age of onset of Menses: _____ Frequency of Menses: _____
Flow: (circle one) Heavy Moderate Light
Pain with Menses: (circle one) Severe Moderate Light None
Date of last period: _____ Date of last Pap Smear: _____
Any history of abnormal Paps: (if yes please specify results, treatments and dates) _____
_____
Are you sexually active? _____ Do you need help with birth control? _____
Type of Birth Control method used (if relevant) _____
Do you practice safe sex? _____
Pregnancies: _____ none _____ full-term _____ premature _____ miscarriages _____ abortions
Infertility? If yes, any work-ups, results and dates: _____
_____
_____
Vaginal Infections? Current, past, and type of symptoms: _____
_____

Any PMS? If yes, timing of symptoms in relation to your menses and symptoms: _____
_____
_____
Any history of DES exposure? _____
Date of last mammogram and results: _____
Date of menopause, if relevant: _____
Any problems associated with menopause? _____
_____

For Men:
Date of last physical exam: _____
Date of last prostate exam: _____ Any problems found? _____
Do you have any difficulty or pain with urination? _____
Do you ever have to get up at night to urinate? If so, how often? _____
Are you sexually active? _____ Do you practice safe sex? _____
Do you have any pain or difficulty with erection? _____ Ejaculation? _____
Any history of male infertility? (If yes, please give diagnosis and treatments tried) _____
_____
_____

For Men And Women:
Family History: Has any blood relative (mother (M), father (F), brother (B), sister (S), grandmother (GM), grandfather (GF), aunt (A), uncle (U), had any of the following conditions, in the past or present? Please indicate if relative is maternal or paternal, (ie. MGM: maternal grandmother, PU: paternal uncle).

Condition **Relative**	**Condition** **Relative**	**Condition** **Relative**
Anemia _____	Arthritis _____	Asthma _____
Allergies _____	Bleeding _____	Constipation _____
Diabetes _____	Drugs/Alcohol _____	Eczema _____
Genetic Disease _____	Glaucoma _____	Herpes_____
Headaches_____	HeartProblem _____	Hypertension _____
KidneyProblem _____	LiverProblem _____	MentalDisorder _____
Osteoporosis _____	Seizure _____	SinusProblem _____
StomachProblem _____	Stroke _____	Thyroid Disease _____
Tuberculosis _____	VeneralDisease _____	

Cancer (specify type) _____
Other _____

Relative	**Heath Status**	**Age**	**If Deceased (cause of and age)**
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____