Dr. Peter Knight
Your Naturopathic Health Partner

222 St. John St. Suite 137, Portland, ME 04102
(207) 805-1129 * www.drpeterknight.com

ADULT HEALTH HISTORY AND FUNCTIONAL HEALTH ASSESSMENT

Name:	**Date of Birth:**	**Today's Date:**

Your responses to the following questions will assist Dr. Knight in evaluating your overall health. It will help in determining the assessments and treatments that are most appropriate and guide your path to optimal health. Please read each question carefully and answer to the best of your ability. It is an extensive form, so please leave yourself the time to fill it out. The more honest you are in your answers, the more useful this tool will be. Please make sure it is completed and returned to Dr. Knight at least 48 hours before your visit so that he has ample time to review it.

What is the primary reason for your appointment with Dr. Knight?

Are there other issues, topics, etc. that you would like to discuss with Dr. Knight?

Please list treatments you are using for your current health issues: (Supplements, drugs, dietary changes, lifestyle changes etc.) The more specific you can be, the better.

MEDICAL HISTORY (Please check any conditions that you currently have or have had):

❒Arthritis
❒Allergies/ hay Fever
❒Asthma
❒Alcoholism
❒Alzheimer's disease
❒Autoimmune disease
❒Blood pressure issue
❒Celiac disease
❒Chronic bronchitis
❒Cancer
❒Chronic fatigue syndrome
❒Carpal tunnel syndrome
❒Cholesterol, elevated
❒Circulatory problems
❒Colitis
❒Constipation
❒Decreased sex drive
❒Dental problems
❒Depression
❒Diabetes
❒Diverticular disease
❒Drug addiction
❒Eating disorder
❒Epilepsy
❒Emphysema
❒Environmental sensitivities
❒Fibromyalgia
❒Food intolerance
❒Gastroesophogeal reflux
❒Genetic disorder
❒Glaucoma
❒Gout
❒Heart disease
❒Infertility
❒Infection, chronic
❒Inflammatory bowel disease
❒Irritable bowel disease
❒Kidney or bladder disease
❒Learning disabilities
❒Liver or gallbladder disease
❒Menstrual irregularities
❒Mental illness
❒Migraine headaches
❒Neurological problems
❒Prostate issues
❒Sinus problems
❒Stroke
❒Thyroid problems
❒Obesity
❒Osteoporosis
❒Ovarian cysts
❒Premenstrual syndrome
❒Pneumonia
❒Skin problems
❒Tuberculosis
❒Ulcers
❒Urinary tract infections
❒Varicose veins
❒_____
❒_____

FAMILY HEALTH HISTORY (PARENTS AND SIBLINGS) (Please check any conditions that members of your family have or have had):

❒Arthritis
❒Asthma
❒Alcoholism
❒Alzheimer's disease
❒Autoimmune disease
❒Cancer
❒Celiac /gluten intolerance
❒Depression
❒Diabetes
❒Drug addiction
❒Eating disorder
❒Genetic disorder
❒Glaucoma
❒Heart disease
❒Infertility
❒Inflammatory bowel disease
❒Learning disabilities
❒Mental illness
❒Migraine headaches
❒Neurological disorders
❒Obesity
❒Osteoporosis
❒Stroke
❒Suicide

HEALTH HABITS

Tobacco

❒ Current smoker
Cigarettes per day: _____
❒ Past smoker Year quit: _____
# of years as a smoker: _____

Alcohol

Wine: # of glasses/ week: _____
Beer: # of glasses/ week: _____
Liquor: # of ounces/ week: _____

Caffeine

Coffee: # oz/ day: _____
Caffeinated Tea: # oz/ day: _____
Soda w/caffeine: #oz/ day: _____
Other (energy drinks etc.) #oz/ day: _____

Water

oz/ day: _____

Exercise

#of days / week: _____
#of hours/ day: _____
Type of exercise:_____

NUTRITION HISTORY

Do you currently follow a special diet or nutritional program? ❒ Yes ❒ No
If yes, which one(s)? (check all that apply)

❒ Low fat
❒ Low carbohydrate
❒ High protein
❒ Low sodium
❒ Dairy Free
❒ Gluten Free
❒ Vegetarian
❒ Vegan
❒ Raw foods
❒ Paleo
❒ Other (describe):
_____
_____
_____

Do you avoid any particular foods? ❒ Yes ❒ No
If yes, which ones and why? _____
_____

Do you have a sensitivity or intolerance to any foods? ❒ Yes ❒ No
If yes, which ones?_____

Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, or hives, etc.? ❒ Yes ❒ No
If yes, are these associated with a particular food, meal, or supplement? ❒ Yes ❒ No
If yes, please name the food or supplement and describe the symptom(s) they cause. _____
_____

Do you cook? ❒ Yes ❒ No If no, who does the cooking? _____

Do you grocery shop? ❒ Yes ❒ No If no, who does?_____

Where does your food come from? (check all that apply)

❒ Hannaford/ Shaws
❒ Whole Foods
❒ Trader Joe's
❒ Farmer's Market
❒ CSA
❒ Garden
❒ Convenience store
❒ Royal River
❒ Lois's
❒ Walmart/ Target
❒ Other _____
_____

Do you feel ***better*** when you eat a lot of:

- ❒ high fat foods
- ❒ high protein foods
- ❒ high carbohydrate foods (bread, potatoes, pasta)
- ❒ refined sugar
- ❒ fried foods
- ❒ 1 or 2 alcoholic drinks
- ❒ gluten
- ❒ dairy
- ❒ Other:_____

Do you feel ***worse*** when you eat a lot of:

- ❒ high fat foods
- ❒ high protein foods
- ❒ high carbohydrate foods (bread, potatoes, pasta)
- ❒ refined sugar
- ❒ fried foods
- ❒ 1 or 2 alcoholic drinks
- ❒ gluten
- ❒ dairy
- ❒ Other:_____

How does skipping a meal affect you? _____
_____

Are there foods that you crave or that you have binged on? ❒ Yes ❒ No
If yes, which foods?_____

Are there any foods that you don't like? ❒ Yes ❒ No
If yes, which foods?_____

BOWEL FUNCTION

How frequently do you have a bowel movement? ❒ more than 3x/day ❒ 1 to 3x/day ❒ every other day ❒ 2 to 3x/week ❒ 1x/ week ❒ less than 1x/week

What is the typical consistency of your bowel movements? ❒ soft and well formed ❒ hard ❒ loose but not watery ❒ diarrhea ❒ pellet like ❒ thin, long or narrow ❒ difficult to pass ❒ alternating between loose and hard ❒ varies a lot

What is the typical appearance of your bowel movements? ❒ medium brown ❒ very dark or black ❒ yellow ❒ green ❒ blood is visible ❒ mucous is visible ❒ undigested food is visible ❒ greasy or shiny ❒varies a lot

How frequently do you have intestinal gas? ❒ never ❒ daily ❒ occasionally ❒ excessively

Have you recently noticed a change in your bowel function? ❒ Yes ❒ No
If yes, please describe:_____

EXPOSURES

Are you exposed to second hand smoke on a regular basis? ❒ Yes ❒ No

Do you have any mercury ("silver") amalgam fillings? ❒ Yes ❒ No
Have you had any mercury amalgam fillings removed? ❒ Yes ❒ No
When?_____ By whom?:_____

What is your water source? ❒ Municipal/City ❒ Private Well ❒ Other:_____

Do you use a water filter? ❒ Yes ❒ No If yes, what type?_____
When was your home built? _____

Do you have your clothes dry cleaned frequently? ❒ Yes ❒ No

Have you been exposed to any of these toxic compounds in your home, job, school, or hobbies?
❒ lead ❒ mercury ❒ arsenic ❒ aluminum ❒ cadmium ❒pesticides ❒ herbicides ❒ solvents
❒ mold ❒other:_____

Have you lived or traveled outside of the United States? ❒ Yes ❒ No
If yes, when and where? _____

Do you feel worse during a certain time of the year? ❒ Yes ❒ No
If yes, when?_____

SLEEP

Do you have trouble falling asleep? ❒ Yes ❒ No
Do you have trouble staying asleep? ❒ Yes ❒ No
Do you feel rested upon awakening? ❒ Yes ❒ No
How many hours do you sleep per night on average? ❒ >10 ❒ 8-10 ❒6-8 ❒ <6
Do you snore? ❒ Yes ❒ No
Do you use sleeping aids? ❒ Yes ❒ No
If yes, what?_____ How often?_____

For the questions on the following pages check all that apply and answer "in general." The following sections are designed to assess your overall health and you will find that some questions are repeated in multiple sections. Make sure you answer them even if you have already answered it elsewhere in order to optimize the usefulness of this form.

SECTION 1

	Yes
1. Are your nails soft, cracked, or brittle?	
2. Is your skin dry, itchy, or flaking?	
3. Is your ear wax hard?	
4. Do you have tiny bumps on the back of your upper arms?	
5. Do you have dandruff?	
6. Are your joints frequently stiff or achy?	
7. Are you thirsty most of the time?	
8. Do you have less than two bowel movements a day?	
9. Are your stools hard or light in color?	
10. Do you have depression, ADHD, or memory loss?	
11. Do you have high blood pressure?	
12. Do you have fibrocystic breasts?	
13. Do your premenstrual symptoms often interfere with your daily living?	
14. Are your cholesterol or triglyceride levels elevated?	
15. Are you of North Atlantic genetic descent (*Irish, Scottish, Welsh, English, Scandinavian)?*	

SECTION 2

	Yes
1. Do you frequently feel down or depressed?	
2. Are you physically a low energy person?	
3. Are you mentally a low energy person?	
4. Do you frequently struggle to get motivated to exercise?	
5. Do you frequently have trouble concentrating or focusing on things?	
6. Do you often sleep a lot?	
7. Do you frequently have trouble waking up in the morning?	
8. Do you need caffeine in the morning to feel alert and awake?	

SECTION 3

	Yes
1. Is it hard for you to relax?	
2. Are you easily stressed out or overwhelmed?	
3. Is it common for you to feel overworked?	
4. Is your body stiff or does it often feel tight?	
5. Do you sometimes feel weak and shaky?	
6. Are you bothered by loud noises, lights, or too much activity?	
7. Do you feel more anxious or stressed if you skip a meal?	
8. Do you use sugar, alcohol, or drugs to help you relax?	

SECTION 4

	Yes
1. Do you frequently have trouble falling asleep?	
2. Do you wake in the middle of the night and have trouble getting back to sleep?	
3. Do you wake too early in the morning?	
4. Do you crave carbohydrates such as bread and pasta?	
5. Do you feel better after you exercise?	
6. Do you have muscle aches, fibromyalgia, and/ or TMJ?	
7. Have you felt better when taking antidepressant medications?	
8. Would you describe yourself as a half glass empty person?	
9. Do you often have low self esteem?	
10. Do you often have low self confidence?	
11. Do you tend to have obsessive thoughts or behaviors?	
12. Do you get the "winter blues" or suffer from "seasonal affective disorder"?	
13. Do you tend to be irritable, easily angered, or impatient?	
14. Are you afraid of heights, crowds, or public speaking?	
15. Do you tend to feel anxious or have you had panic attacks?	

SECTION 5

	Yes
1. Do you eat animal protein (meat, chicken, dairy, cheese, eggs) more than 5 times a week?	
2. Do you eat less than one serving of green vegetables a day?	
3. Do you eat less than 5 servings of fruits and vegetables a day?	
4. Do you have more than 3 alcoholic drinks a week?	
5. Are you frequently depressed?	
6. Do you have a history of heart attack or heart disease?	
7. Do you have history of stroke?	
8. Do you have a history of cancer?	
9. Have you ever had an abnormal PAP test?	
10. Do you have a family history of birth defects?	
11. Do you have a family history of dementia?	
12. Do you have a family history of multiple sclerosis or Parkinson's disease?	
13. Do you have decreased sensation in your feet?	
14. Do you have a history of carpal tunnel syndrome?	
15. Are you over 65 years old?	

SECTION 6

	Yes
1. Do you find it difficult to do math in your head?	
2. Do you have to write things down so that you don't forget them?	
3. Do you have a hard time finding the right words to say?	
4. Do you have a hard time remembering what you were saying if interrupted?	
5. Do you get nervous when you have to learn something new?	
6. Do you find it hard to follow the plot when reading a book or watching a movie?	
7. Do you frequently misplace your keys, glasses, or wallet?	
8. Do you have trouble focusing during long conversations or meetings?	
9. Do you feel like your brain is not functioning at its peak?	

Section 7

	Yes
1. Is your sense of taste impaired?	
2. Is your sense of smell impaired?	
3. Are your nails thin, brittle, or peeling?	
4. Do you have white spots on your nails?	
5. Do you have frequent colds or respiratory infections?	
6. Do you have frequent diarrhea or loose stools?	
7. Do you have eczema or psoriasis?	
8. Do you have acne?	
9. Do your wounds take a long time to heal?	
10. Do you have environmental allergies?	
11. Are you experiencing hair loss or change in hair texture?	
12. Do you have an enlarged prostate?	
13. Do you have inflammatory bowel disease (ulcerative colitis or Crohn's disease)?	
14. Do you have rheumatoid arthritis or other autoimmune diseases?	
15. Do you consume more than three alcoholic beverages per week?	
16. Do you sweat excessively?	
17. Do you take diuretic medications?	
18. Do you have liver or kidney disease?	

Section 8

	Yes
1. Do you have thickened skin or fingernails?	
2. Is your skin dry?	
3. Is your hair thinning?	
4. Is your hair coarse?	
5. Are you sensitive to cold?	
6. Are your hands and feet frequently cold?	
7. Do you have muscle fatigue, pain, or weakness?	
8. Do your premenstrual symptoms interfere with your daily living?	
9. Is your sex drive decreased?	
10. Do you retain fluid in your face, hands or feet?	
11. Do you feel fatigued, especially in the morning?	
12. Is your blood pressure usually low?	
13. Do you have trouble with memory or concentration?	
14. Are your eyebrows thinning?	
15. Do you have trouble losing weight, or frequent weight gain?	
16. Are you frequently constipated?	
17. Are you frequently depressed?	
18. Do you have an autoimmune disease (i.e. rheumatoid arthritis or lupus)?	
19. Do you have celiac disease or gluten sensitivity?	
20. Have you been exposed to radiation treatments?	
21. Do you have multiple mercury containing dental amalgams?	
22. Do you frequently eat tuna, swordfish, or halibut?	

Section 9

	Yes
1. Have you been diagnosed with depression?	
2. Do you tend to be irritable?	
3. Do you have attention deficit disorder?	
4. Do you get anxious easily or suffer from panic attacks?	
5. Do you frequently have insomnia or trouble falling asleep?	
6. Do you have muscle twitching?	
7. Do your premenstrual symptoms interfere with your daily living?	
8. Do you frequently get leg or hand cramps?	
9. Do you have restless leg syndrome?	
10. Do you experience heart palpitations?	
11. Do you get frequent headaches or migraines?	
12. Do you have trouble swallowing?	
13. Are you sensitive to loud noises?	
14. Do you frequently feel fatigued?	
15. Do you have asthma?	
16. Do you tend to be constipated? (Less than 2 bowel movements a day)	
17. Do you tend to feel stressed?	
18. Do you have mitral valve prolapse?	
19. Do you have diabetes or insulin resistance?	
20. Do you have generalized muscle tightness or pain?	

Section 10

	Yes
1. Do you crave sweets?	
2. Do you get a temporary boost in energy after eating sweets followed by a crash in energy?	
3. Do you have diabetes or insulin resistance?	
4. Do you have a family history or diabetes or insulin resistance?	
5. Do you get irritable, anxious, tired, jittery, or experience headaches throughout the day, but feel better temporarily after eating?	
6. Do you feel shaky two to three hours after a meal?	
7. Do you eat a low fat diet, but have difficulty losing weight?	
8. Are you cranky, tired or irritable if you miss a meal?	
9. Do you have trouble stopping eating sweets or carbohydrates once you start eating them?	
10. Do you get heart palpitations after meals?	
11. Are you often moody, impatient, or anxious?	
12. Do you have difficulty with memory or concentration?	
13. Does eating make you calm?	
14. Do you get night sweats?	
15. Are you tired most of the time?	
16. Do you have extra weight around your abdomen?	
17. Do you have thinning hair?	
18. Do you have high blood pressure?	
19. Do you have chronic fungal infections?	

Section 11

	Yes
1. Do you feel bloated after meals?	
2. Do you experience belching or heartburn after meals?	
3. Do you experience flatulence after meals?	
4. Do you have chronic yeast or fungal infections?	
5. Do you feel nauseous after taking supplements, particularly multivitamins?	
6. Do you feel fatigued of have trouble concentrating after eating?	
7. Does your food sit in your stomach "like a rock" after eating?	
8. Do you have heartburn or reflux?	
9. Do you regularly take antacid medications?	
10. Do you have chronic abdominal pains?	
11. Do you frequently have diarrhea?	
12. Do you frequently have constipation?	
13. Do you notice undigested food in your stool?	
14. Do you have foul smelling stools?	
15. Do you have food allergies, food intolerances, or food sensitivities?	
16. Do carbohydrates cause you to have bloating?	
17. Do you get frequent canker sores?	
18. Have you used antibiotics more than twice in the last three years?	
19. Do you frequently take ibuprofen, aspirin, or other anti-inflammatory medications?	
20. Do you take oral contraceptive pills?	

Section 12

	Yes
1. Do you have seasonal or environmental allergies?	
2. Do you have food allergies or sensitivities?	
3. Do you work in an environment with poor ventilation?	
4. Are you frequently exposed to pesticides or toxic chemicals?	
5. Do you frequently consume tuna, swordfish, or halibut?	
6. Do you have mercury containing amalgam fillings?	
7. Do you get frequent colds or infections?	
8. Do you have a history of chronic infections such as hepatitis, skin infections, or cold sores?	
9. Do you have chronic sinusitis?	
10. Do you have chronic bronchitis or asthma?	
11. Do you have eczema, psoriasis, acne or other skin rashes?	
12. Do you have arthritis?	
13. Do you suffer from an autoimmune condition such as rheumatoid arthritis, lupus, or Hashimoto's thyroiditis?	
14. Do you have colitis or inflammatory bowel disease?	
15. Do you have irritable bowel syndrome?	
16. Do you have history or heart disease or heart attack?	
17. Are you overweight or have diabetes?	
18. Do you have or have a family history of Parkinson's, Alzheimer's, or multiple sclerosis?	
19. Do you find your life to be overly stressful?	
20. Do you consume more than three glasses of alcohol a week?	
21. Do you have gingivitis or bleeding gums?	

Section 13

	Yes
1. Is your blood pressure low?	
2. Do you get dizzy when you stand up?	
3. Have you been diagnosed with hypoglycemia?	
4. Do you crave sugar?	
5. Do you crave salt?	
6. Do you frequently have dark circles under your eyes?	
7. Do you have trouble falling/ staying asleep?	
8. Do you feel groggy or unrefreshed upon waking?	
9. Do you experience mental fogginess or trouble concentrating?	
10. Do you get frequent headaches?	
11. Do you get frequent infections such as colds?	
12. Do you tire easily while exercising or feel very fatigued after exercising?	
13. Do you often feel stressed?	
14. Do you simultaneously feel wired and tired?	
15. Do you have water retention?	
16. Do you have panic attacks or startle easily?	
17. Do you experience heart palpitations?	
18. Do you need to start the day with caffeine?	
19. Do tolerate caffeine poorly?	
20. Do you often feel weak or shaky?	
21 Do you get sweaty palms and feet when you are nervous?	
22. Do you often experience fatigue?	
23. Do you often experience muscle weakness?	
24. Do you need to have an afternoon cup of coffee or other caffeinated beverage?	
25. Do you tend to just eat carbohydrates at breakfast (cereal, bagel, toast)?	

Section 14

	Yes
1. Do you have the “winter blues” or “seasonal affective disorder”?	
2. Do you have a loss of mental sharpness or memory?	
3. Do you have muscle weakness?	
4. Do you work indoors?	
5. Do you avoid the sun?	
6. Do you wear sun block when in the sun for extended periods of time?	
7. Do you have osteoporosis?	
8. Have you broken more than two bones in the last 20 years?	
9. Do you have an autoimmune disease?	
10. Do you have arthritis?	
11. Do you have frequent infections?	
12. Is your skin dark?	

Section 15

	Yes
1. Are you frequently constipated or have hard to pass stools?	
2. Do you only urinate two to three times a day?	
3. Do you rarely break a sweat?	
4. Do you experience fatigue, muscle aches, headaches, concentration, or memory problems?	
5. Do you have fibromyalgia or chronic fatigue syndrome?	
6. Do you drink unfiltered water?	
7. Do you have your clothes dry cleaned?	
8. Do you work or live in a building with poor ventilation or windows that do not open?	
9. Do you live in an urban or industrial area?	
10. Do you use lawn or garden chemicals or have you home treated for bugs by an exterminator?	
11. Do you use non-stick cookware?	
12. Do you have more than one or two mercury amalgam fillings?	
13. Do you eat tuna, halibut, or swordfish more than once a week?	
14. Are you bothered by any of the following odors? (gasoline, perfume, new cars, fabric stores, dry cleaning, hair spray, cleaning products, fabric softeners, soaps, detergents, tobacco, or chlorinated water)	
15. Do you have a negative reaction when you consume foods containing garlic, onions, MSG, sulfites, sodium benzoate, red wine, aged cheese, bananas, chocolate, or even small amounts of alcohol?	
16. When you drink coffee or other caffeinated beverages do you feel wired, have increased muscle or joint aches, or feel anxious or dizzy?	
17. Do you regularly consume any of the following medications: acetaminophen (Tylenol), acid blocking medications, oral contraceptive pills, cholesterol lowering medications, ibuprofen, naproxen, or antifungal medications?	
18. Have you had jaundice (turned yellow) or been told you have Gilbert's syndrome?	
19. Do you have or have a family history of cancer?	
20. Do you have or have a family history of neurological conditions such as Parkinson's, Alzheimer's, multiple sclerosis, or ALS?	

Thank you for taking the time to complete this form. The answers will help assist Dr. Knight in determining the next steps helping you to achieve more optimal health.