Dr. Peter Knight
Your Naturopathic Health Partner

975 Broadway, Floor 1, South Portland ME 04106
(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
❒Gastroesophageal 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?_____

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.