

**Dr. Julia Parke, N.D.**

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**~PURE Naturopathic Healthcare****Patient Information**

Name	DOB	Gender	M	F
Address		Email		
Home Phone		Mobile Phone		
Emergency Contact				
Name	Relationship to you	Phone		

**Note:** Naturopathic, Holistic, and Preventative health care are only possible when the doctor has a complete picture of the patient, physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. This record is confidential and may be released only with your written authorization. Thank you.

Have you seen a doctor that practices natural or integrative medicine before? Y/N  
 If so, what type of natural medicine oriented clinicians have you visited?

Naturopathic Doctor  Holistic MD/DO  Acupuncturist  Chiropractor  Other:

How did you find us?

Doctor Referral  Patient Referral  web search  YouTube Video

If you were referred, please let us know by whom:

Do you have questions about Naturopathic Medicine?

What are your health goals?

Do you have health insurance? Y/N

If Yes, HMO or PPO?

Who is your insurance carrier?

Please list other health care providers you are currently working with:

Name	Specialty	Contact Info
Primary Care		
1.		
2.		
3.		
4.		
5.		



<b>Personal &amp; Family Diagnosed Health Conditions</b>	YES	Who? Indicate self or a specific family member	Notes:
ADD/ADHD	<input type="checkbox"/>		
Alcohol/drug addiction	<input type="checkbox"/>		
Anemia	<input type="checkbox"/>		
Alzheimer's/Dementia	<input type="checkbox"/>		
Arthritis (Osteo or Rheumatoid?)	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>		
Autoimmune diseases	<input type="checkbox"/>		
Birth defects	<input type="checkbox"/>		
Blood disorder	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>		What kind?                      Age diagnosed?
Cardiovascular Disease	<input type="checkbox"/>		
Depression	<input type="checkbox"/>		
Diabetes Type 2	<input type="checkbox"/>		
Diverticulosis	<input type="checkbox"/>		
Eating Disorder	<input type="checkbox"/>		
Eczema	<input type="checkbox"/>		
Epilepsy/Seizure Disorder	<input type="checkbox"/>		
Fibromyalgia	<input type="checkbox"/>		
Gallstones/Gall Bladder Disease	<input type="checkbox"/>		
Gout	<input type="checkbox"/>		
High Cholesterol	<input type="checkbox"/>		
HIV/Aids	<input type="checkbox"/>		
Hypertension	<input type="checkbox"/>		
Inflammatory Bowel Disease	<input type="checkbox"/>		
Kidney Disease	<input type="checkbox"/>		
Learning Disability	<input type="checkbox"/>		
Liver Disease - If Y, specify:	<input type="checkbox"/>		
Mental illness – If Y, specify:	<input type="checkbox"/>		
Neurologic disorder	<input type="checkbox"/>		
Osteopenia/Osteoporosis	<input type="checkbox"/>		
Stomach or Duodenal Ulcers	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>		
Thyroid disease	<input type="checkbox"/>		
Other:	<input type="checkbox"/>		

**Prescribed medications and over the counter medications – attach a separate list if necessary**

Medication Name	Dose	When started?	Why?
1.			
2.			
3.			
4.			
5.			

**Drug Allergies?**

Any known medication allergies? Y/N \_\_\_\_\_

If Yes, which medications: \_\_\_\_\_

What allergic reaction symptoms do you experience? \_\_\_\_\_

**Supplements – please list all vitamins/botanicals, homeopathics, etc.**

Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started	Why
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

## Lifestyle and Social History

### Diet

Do you follow any special diet type or restrictions?	Are there foods you crave strongly?
What foods make you feel poorly? Explain:	What foods make you feel the best? Explain:

How would you describe your relationship with food?

Number of meals a day:

Number of snacks a day:

Who typically cooks your food?

Where do you typically purchase your food?

**Please list typical foods consumed daily – specify typical times of day for each:**

Breakfast	
Lunch	
Dinner	
Snacks	
Sweets	
Water	How much? Tap? filtered, bottled? Are you generally thirsty?

Foods you avoid?

Primary sources of protein?

**List the foods you ate with in the last 24 hours:**

Breakfast:

Lunch:

Dinner:

Please check the appropriate box below to indicate the frequency of consumption:

Daily      Weekly      Monthly      Occasionally (1-2x per mo)      Rarely (1-2x per yr)      Never

Sugar	
Artificial sweeteners	
Fast food	
Fried food	
Processed food	
Flour/baked goods	
Caffeine	
Soda?	
Alcohol?	

Notes/details:

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### Habits

Do you smoke cigarettes? Y/N	Packs per day?	Duration of habit?
	Past Use?	If so, how long ago did you quit?
Do you use recreation drugs? Y/N	If Y, what type?	
	How often?	
	Past Use?	If so, how long ago did you quit?
Have you ever been treated For drug/alcohol addiction? Y/N	If Y, describe:	How long ago?

### Exercise

Do you exercise regularly? Y/N	How often?	For how long?
What type of exercise(s) do you do?		

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## Sleep

How many hours of sleep do you get regularly each night?	Time you go to bed?	
Do you fall asleep easily? Y/N	Do you sleep soundly? Y/N	Time you get up?
Do you wake rested? Y/N	What is your AM mood like?	

Notes:

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## Occupation

What is your occupation?	Do you like your work? Y/N
Number of hours worked per week:	Do you like your work environment? Y/N If no, please explain:

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## Stress Level

Rate 1-10 (1 = Very Low, 10 = High)	Source(s) of stress:
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What do you do to cope with stress?

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## Sense of Well-being

Rate your sense of wellbeing from 1-10 (1 = Very Low, 10 = High)	How would you define your emotional state?
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What do you do to regularly support your health and well-being?

What challenges do you face with your efforts to maintain health?

Where do you feel you could use more support?

Do you cry a lot?

How do you express anger?

Do you have a history of suppressing desire or emotion?

Do you consider that your complaint dates from any particular incident, aspect or disease?      Y      N  
Please describe however trivial or irrelevant they may seem.

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## **PURE Naturopathic Healthcare**

**PURE Naturopathic Healthcare** is a cash-based practice that accepts cash, check or credit card payment. Payment is required on the day services are rendered. We do not file insurance claims but we will provide you with a “super-bill” that contains the diagnosis and procedure codes required for insurance reimbursement. Pure Health assumes no responsibility for services not reimbursed by your insurance company.

I have read, understand, and agree to the above policies:

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Please Print Your Name

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Signature

Date