

Eden-Whild Client History Form

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Today's Date:		
Name:	F:	M: L:
Mailing Address:		
CITY, STATE, ZIP	C:	S: Z:
Telephone - (H):	()	
Telephone - (W):	()	
Referred by:		
Gender: (circle one):	Male • Female • Other	Birthdate: (MM/DD/YYYY)
Marital Status: (circle one):	Single • Married • Divorced • Widowed • Other	
What is Your Current Weight?		Height?
What was your last blood pressure reading:		
Date of Last Medical Exam:		
Tests Performed:		
List any Abnormal test results: (please send copies of any abnormal test results)		
Family Medical History Please list any medical problems within your family in the appropriate places below:		
MOTHER:		
If Living...		
Age:		
Major Health Issues? (please list)		
If Deceased...		
Age at Time of Death:		
Cause of Death?		

FATHER:	
If Living...	
Age:	
Major Health Issues? (please list)	
If Deceased...	
Age at Time of Death:	
Cause of Death?	
SISTER(S):	
If Living...	
Age(s):	
Major Health Issues? (please list)	
If Deceased...	
Age at Time of Death:	
Cause of Death?	
BROTHER(S):	
If Living...	
Age(s):	
Major Health Issues? (please list)	
If Deceased...	
Age at Time of Death:	
Cause of Death?	
If there is a history of any of the following Illnesses in your Family, please indicate who had it and the age of onset	
Breast Cancer:	
Ovarian Cancer:	
Prostate Cancer:	
Colon Cancer:	
Other Cancers:	
Heart Disease:	
Diabetes:	
Neuro-muscular	
Osteoporosis	
Other: (please describe:)	

Your Medical History			
(please include the date and description for any items indicated below)			
Obstetrics: (list any pregnancies and the outcome)			
Surgeries:			
Medical Problems:			
Blood Transfusions:			
Drug Allergies: (please indicate drug and type of reaction)			
Indoor and Outdoor Allergies:			
Menstrual History:			
Age of first period:		Amount of flow:	
# Days between periods:		# Days period will last:	
Any pain with Period? (If so, what do you take?)			
Sexual History and Abuse			
Age of First Intercourse:		Number of partners in life:	
Pain or problems with Intercourse			
Do you currently have a partner		Number of years:	
Have you had any sexually transmitted Dieases: (what type and when treated?)			
Have you ever had flash backs or recalls of any sexually abuse			
If so, what age and did you receive counseling			
Have you ever been involved with any domestic violence issues			
If So, at what Age?		And with whom?	
Did you receive counseling for this abuse?			

Other Personal Hygiene and Lifestyle Information

Do you douche? (if so what do you use and how often)			
Do you use tampons? (What type? How many hours per day?)			
Do you use Pads? (What type?)			
What kind of soap do you wash your body with?			
Do you wear underpants to bed at night?			
Do you ever leak urine? (when and why?)			
Do you get up at night and void? (how many times a night?)			
What time do you go to bed at night?			
Do you fall asleep with no problem?			
Do you sleep soundly?			
Do you dream?			
What time do you get up in the morning?			
How often do you find yourself "stressed?" Why?			
What do you do to de-stress yourself?			
Do you practice deep breathing techniques?			
Do you believe in God or some type of higher power?			
Do you attend a church?			
Do you pray? How often?			
Frequency of bowel movements?		Stool Color and Consistency?	
Do your stools float in the water?		Do you Use laxatives?	
Type of Laxative?		How Often Used?	
Is your skin dry?			
Do your fingernails split easily?			
Is your hair dry?			

What form of birth control are you now using			
What form have you used in the past			
Do you presently smoke?		How much?	
Have you tried to quit smoking?		How and When?	
What type of work do you do?			
Where do you work, and for how long?			
Are you happy with your job? Why or Why not?			
How many years did you attend school?			
Do you have an active social life?			
Are you bored?			
What are your hobbies?			
Do you think you are happy and satisfied with your life?			
Drugs, Medications and Supplements			
Please list all the Prescription Drugs or Medications that you are taking. Include why and when you take them.			
Please list all the "Over The Counter" Medications that you take. Include why and when you take them.			
Please list all the Supplements that you take, including Vitamins/Herbs. Include type, dose and why and when you take them.			
Street Drugs: Do you use any recreational drugs now or in the past? If so, what Type?			
Diet and Nutrition (Please send me an example of what you eat and drink on a regular basis - keep a diary for at least 3 days)			
How much caffeine do you take in daily? In what form?			
Do you drink tea? Black or Green? With or without cream or milk?			

<p>Do you drink carbonated beverages? What type? How much?</p>	
<p>Do you use Aspartame? In what product? How much?</p>	
<p>Do you use sugar? How much? When?</p>	
<p>Do you drink water? How much? When? Type?</p>	
<p>Do you drink milk? How much? Type?</p>	
<p>How often do you eat red meat?</p>	
<p>Do you eat fish? What kind? How often?</p>	
<p>Do you eat fried foods? How often?</p>	
<p>Do you eat sweets-desserts? How often? Do you crave them?</p>	
<p>How often do you consume alcoholic beverages? How much? What kind?</p>	
<p>Do you exercise? How often? What type?</p>	
Overview	
<p>What do you consider to be your problem areas? Please list and describe if possible.</p>	
<p>What do you want to accomplish? What are your goals?</p>	
<p>Do you have any questions at this time?</p>	
<p>I will work up a program that will be geared specifically for your needs. Please do not share with others, this is your program. You will find tinctures, herbs, vitamins, supplements, salves etc. listed in your program. These may be purchased from Eden-Whild if you wish. I will mail them to you as needed.</p> <p>It will take sometimes at least 3 months to see a change in your system. Keep in close contact with me, if you have a question feel free to call. If a new condition arises call me, try natural first.</p>	