

# Anamnesis Form

**PLEASE MAKE SURE YOU HAVE ALL 14 PAGES OF THIS FORM**  
**We need three days cancellation notice. Thank you.**

Holistic Health is a state of well-being in which an individual's body, mind, emotions and spirit are in tune with the natural, cosmic and social environment.

Holistic Medicine is defined as a system of health care which emphasizes on personal responsibility, and care, a cooperative relationship among all those involved, leading toward optimal harmony of body, mind, emotions and spirit.

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The following questionnaire, although somewhat long and detailed, is an invaluable source of information about you as a unique person. It will allow us to know the Total you, not just you as a collection of symptoms of an illness.

If, for any reason, you object to fill out any or all of it, you may leave that part blank and provide us with the information you feel comfortable sharing with us.

**PLEASE NOTE:** This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

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Would you be willing to sign a release to obtain medical records from your previous doctor(s) and hospital(s), if this information would be helpful for your treatment?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, then sign below.

## **AUTHORIZATION FOR MEDICAL INFORMATION**

This will authorize (Dr.) \_\_\_\_\_ of  
(Clinic) \_\_\_\_\_

to provide KURT HARTMANN ND , or his representative, with any and all information in regards to any form of treatment applied to me, including blood tests, X - rays, findings and diagnoses.

A copy of this authorization is valid as well as an original.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

### **NOTICE: Very Important Please Read**

We are by **appointment only** in our clinic and other patients are waiting for the time with our Naturopath. To reduce waiting times for you we try hard to be punctual so we reserve lots of time just for your appointment. When you have to cancel your appointment **we need to know by 10:00 am three days before** your appointment. With every late cancellation we are not able to fill that reserved time, so **you will be charged for the missed appointment.**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ REFERRAL THROUGH : \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_  
DATE OF LAST CHEST X - RAY: \_\_\_\_\_  
DATE OF LAST EKG: \_\_\_\_\_  
DATE OF LAST LAB WORK (BLOOD, URINE): \_\_\_\_\_  
LIST ANY ABNORMAL RESULTS: \_\_\_\_\_

**SYMPTOMS YOU PRESENTLY HAVE:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**NO SYMPTOMS: DESIRE ROUTINE CHECK - UP ( )**

**LIST OF PHYSICANS YOU ARE PRESENTLY SEEING:**

NAME	SPECIALTY	LOCATION
1: _____		
2. _____		

**MEDICINES/DRUGS: List all chemical substances you are taking, even if they are nonprescription (over the counter).**

NAME	DOSE	REGULARITY	HOW LONG HAVE YOU BEEN TAKING IT
1: _____			
2. _____			
3. _____			
4. _____			

**SUPPLEMENTS: Any vitamins, minerals or similar health products**

	<u>NAME</u>	<u>DOSE</u>	<u>REGULARITY</u>	<u>HOW LONG HAVE YOU BEEN TAKING IT</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

**FAMILY MEDICAL HISTORY**

	<u>if living</u>	<u>Health</u>	<u>if passed away</u>	<u>Cause</u>
	<u>Age</u>		<u>Age at death</u>	
<b>Father</b>	_____	_____	_____	_____
<b>Mother</b>	_____	_____	_____	_____
<b>Brother or Sister</b>				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
<b>Husband or Wife</b>	_____	_____	_____	_____
<b>Children</b>				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

<b>Has any blood relative ever had</b>	<b>( please circle )</b>		<b><u>Who?</u></b>
	<b>No</b>	<b>Yes</b>	
<b>Cancer</b>	No	Yes	_____
<b>Tuberculosis</b>	No	Yes	_____
<b>Diabetes</b>	No	Yes	_____
<b>Heart trouble</b>	No	Yes	_____
<b>High blood pressure</b>	No	Yes	_____
<b>Stroke</b>	No	Yes	_____
<b>Epilepsy</b>	No	Yes	_____
<b>Mental illness</b>	No	Yes	_____
<b>Suicide</b>	No	Yes	_____

**ALLERGIES: Are you allergic to**

**1. Any medicine or drug? No Yes**  
 if yes, to which  
 ones: \_\_\_\_\_

**2. Any kind of food? No Yes**  
 if yes, to what kind  
 \_\_\_\_\_

**3. Anything carried in the air? No Yes**  
 if yes, to what  
 \_\_\_\_\_

**4. Any other allergies, please list:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**PERSONAL HISTORY:**

**ILLNESSES: Have you ever had:**

Measles	No	Yes	Migraine headaches	No	Yes	
German measles	No	Yes	Tuberculosis	No	Yes	
Mumps		No	Yes Diabetes		No	Yes
Chicken pox	No	Yes	Cancer	No	Yes	
Whooping cough	No	Yes	High or low blood pressure	No	Yes	
Scarlet fever or Scarlentina	No	Yes	Colitis or other bowel diseases	No	Yes	
Diphtheria	No	Yes	Hemorrhoids or any rectal dis.	No	Yes	
Small pox	No	Yes	Nervous breakdown	No	Yes	
Pneumonia	No	Yes	Food, chemical or drug poisoning	No	Yes	
Influenza	No	Yes	Hay fever or asthma	No	Yes	
Pleurisy	No	Yes	Hives or Eczema	No	Yes	
Rheumatic fever or heart disease	No	Yes	frequent infections or boils	No	Yes	
			Any other disease	No	Yes	
Arthritis or Rheumatism	No	Yes				
Any bone or joint disease	No	Yes	INJURIES: have you had any			
Neuritis or neuralgia	No	Yes	Broken or cracked bones	No	Yes	
Bursitis, Sciatica or Lumbago	No	Yes	Sprains	No	Yes	
Polio or Meningitis	No	Yes	Lacerations	No	Yes	
Nephritis	No	Yes	Dislocations	No	Yes	
Gonorrhoea or Syphilis		No	Concussion, or head injuries	No	Yes	
Gallbladder disease	No	Yes	Yes Ever been knocked unconscious	No	Yes	
Anemia	No	Yes	WEIGHT: now _____ one year ago _____			
Jaundice	No	Yes	Maximum _____ when _____			
Bladder disease	No	Yes	HEIGHT: _____ cm / ft.			
Epilepsy	No	Yes				

**HOSPITALIZATIONS:**

	<u>List all surgeries/operations</u>	<u>Year</u>	<u>Reason for it</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

**ANY OTHER HOSPITALIZATIONS:**

	<u>Reason</u>	<u>Year</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Have you ever been advised to have any operations which have not been done? No: \_\_\_\_ Yes: \_\_\_\_\_

How are your sleeping habits? Good \_\_\_\_ Bad \_\_\_\_\_  
 If bad: are you waking at night \_\_\_\_ or having trouble falling asleep \_\_\_\_\_  
 other \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU HAD DURING THE PAST YEAR:**

Frequent or severe headaches	No	Yes	ringing in ears	No	Yes
Fainting spells	No	Yes	Diminishing of hearing	No	Yes
Dizziness on movement	No	Yes	Recurrent nose bleed	No	Yes
Unconscious spells	No	Yes	Recurrent head colds	No	Yes
Blurred vision	No	Yes	Sinus trouble	No	Yes
Double vision	No	Yes	Hay fever	No	Yes
Spots in front of the eyes	No	Yes	Strange persistent odors	No	Yes
Infected eyes	No	Yes	Persistent hoarseness	No	Yes
Pain behind eyes	No	Yes	Difficulty on swallowing	No	Yes
Any change in vision	No	Yes	Enlarged glands	No	Yes
Do you wear glasses	No	Yes	Recurrent sore throats	No	Yes
When was your last check up	_____		Recurrent mouth sores	No	Yes
Earaches	No	Yes	Soreness or bleeding of		
Discharge from ears	No	Yes	gums during brushing	No	Yes

**DO YOU HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR (cont.)**

Chest pain	No	Yes	Difficulty in starting urination	No	Yes
Angina pectoris	No	Yes	Urinate more than before	No	Yes
Coughed up blood	No	Yes	Urinate less than before	No	Yes
Pain in arm(s)	No	Yes	Any blood in urine	No	Yes
Night sweats	No	Yes	How much water do you		
Chronic or frequent cough	No	Yes	drink a day	_____	/ liter
Chronic or frequent cough			How many times per day do		
on lying down	No	Yes	you urinate	_____	
Wake up short of breath	No	Yes	Full feeling of bladder but only		
Shortness of breath on:			small amount of urination	No	Yes
walking several blocks	No	Yes	Lose urine on coughing or		
One flight of stairs	No	Yes	sneezing	No	Yes
On lying down	No	Yes	Discharge from penis	No	Yes
Purple lips or fingers	No	Yes	Recurrent back pains	No	Yes
Palpitations, fluttering of heart	No	Yes	Backaches	No	Yes
High blood pressure	No	Yes	Joint pains	No	Yes
Swelling of hands, feet			Swelling of any joints	No	Yes
or ankles	No	Yes	Redness or heat of any joint	No	Yes
At what time of day	_____		Tingling or weakness of hands		
Leg cramps on walking			or feet	No	Yes
or at night	No	Yes	Muscle spasm	No	Yes
Enlarged veins in legs	No	Yes	Loss or change in sensation		
Recurrent stomach pain	No	Yes	of hands or feet	No	Yes
Belching or heartburn	No	Yes	Trembling of any extremity	No	Yes
Relieved by food or medication	No	Yes	Growth in neck or throat	No	Yes
Appetite	good	fair	poor	No	Yes
Nausea or vomiting	No	Yes	Tiredness without apparent		
Avoid some foods	No	Yes	reason	No	Yes
What kinds _____			Brittleness of nails	No	Yes
Avoid spices	No	Yes	Dryness of skin	No	Yes
Like some foods very much	No	Yes	Easy bruising	No	Yes
What kinds _____			Inability to stand heat	No	Yes
Abdominal cramping	No	Yes	Inability to stand cold	No	Yes
Color of bowel movement	_____		Change in hair texture	No	Yes
Consistency of stools			Change in skin texture	No	Yes
Frequency of BM a day/week			Any skin rash	No	Yes
Any blood in bowel movement	No	Yes			
Rectal pain with B.M.	No	Yes	X - RAYS: have you ever had x rays of:		
Change in size shape or texture			Chest	No	Yes
of B.M.	No	Yes	Stomach or colon	No	Yes
Describe _____			Gall bladder	No	Yes
Do you get up at night			Extremities	No	Yes
to urinate	No	Yes	Back	No	Yes
How many times	_____		Teeth	No	Yes
Pain on urinating	No	Yes	Other	No	Yes

**DO YOU HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR (cont.)**

**EKG:**

ever had an electrocardiogram      No    Yes

**IMMUNIZATION:**

Small pox vaccination within last 7 years      No    Yes

Tetanus shots ( not antitoxin which last only two weeks )      No    Yes

Polio shots within last two years      No    Yes

**DRUGS:**

Laxatives      never occ.    freq.    daily

Vitamins      never occ.    freq.    daily

Sedatives      never occ.    freq.    daily

Tranquilizers      never occ.    freq.    daily

Sleeping pills etc.      never occ,    freq.    daily

Aspirin etc.      never occ,    freq.    daily

Cortisone      never occ,    freq.    daily

Thyroid      never, yes, in past, none now daily  
now on \_\_\_\_gr. daily

Appetite depressants      never    occ,    freq.    daily

Have you ever been treated for drug habits      No    Yes

Have you ever taken hormone tablets or injections      No    Yes

**SEX:**

Entirely satisfactory      No    Yes

**WOMEN ONLY-MENSTRUAL HISTORY**

Age at onset \_\_\_\_\_

Regular      No    Yes

Varies

Cycle \_\_\_\_\_ days (from start to start)

FLOW: Heavy      Medium      Light

Any clots passed      No    Yes

Pains or cramps      No    Yes

Date of last period \_\_\_\_\_

Date of last pelvic exam \_\_\_\_\_

Date of last Pap test \_\_\_\_\_

Results:      Neg.    Pos.

Any discharge from Vagina      No    Yes

If so, color \_\_\_\_\_

Amount \_\_\_\_\_

Odor \_\_\_\_\_

Any itching of vaginal area      No    Yes

Do you take birth control pills      No    Yes

How long have you taken them \_\_\_\_\_

**Pregnancies:**

How many children born alive \_\_\_\_\_

How many stillbirths \_\_\_\_\_

How many premature births \_\_\_\_\_

How many cesarean sections \_\_\_\_\_

How many miscarriages \_\_\_\_\_

Any complications with pregnancy      No    Yes

Describe: \_\_\_\_\_

Other: \_\_\_\_\_



**What things are worrying you at the moment?**

**How do worries affect you?**

**At what part of the day do you feel most tired?**

**How do you feel when you wake up in the morning?**

**What sort of things make you feel sad?**

**What sort of things makes you afraid/anxious?**

**How do you feel about having to entertain people?**

**Under what sort of conditions do you become angry?**

**How do you express anger?**

**How do you like being alone?**

**How does time pass you by?**

**Do other people say that you do things quickly? If so what things?**

**When you are depressed, how would you look at death?**

**How do you tolerate waiting?**

**If you receive bad service in a shop or restaurant, how will you respond?**

**Are you hungry between or after meals, if yes, at what time?**

**How is your memory? (If weak, find out in what specific areas?)**

**How is your concentration?**

**How are you about making decisions?**

**Some people are suspicious and others aren't. How do you see yourself in this respect?**

**From your childhood, what memories do come up right away?**

**What about anxieties?**

**Do you remember any dreams? (If yes what are they like?)**

**If you could change one thing in your life what would it be?**

**IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT; AND HAS NOT BEEN ASKED?**

**IF SO, PLEASE FEEL FREE TO SHARE IT WITH US:**

## **NOTICE**

**We are by appointment only in our clinic and other patients are waiting for the time with our Naturopath. To reduce waiting times for you we try hard to be punctual so we reserve lots of time just for your appointment. When you have to cancel your appointment we need to know by 10:00 am three days before your appointment. With every late cancellation we are not able to fill that reserved time. So you have to understand we will charge \$75.00 for the cancellation of a first visit if you do not cancel on time, and \$20.00 for a follow up visit plus G.S.T.**

**Homeopathic and Herbal Medications are very sensitive to light, temperature influences, radiation's and so on. This is why we are asking you to understand we cannot take back any medication even when it is still sealed.**