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PATIENT INFORMATION

Name: ____ Date: __________________

Address: ____

City: ______________________________ State: ________________ Zip Code: _____________

Telephone # (home):_______________________ (cell): ____________________________

(work): _______________________

E-mail address: ____

Age: ________ Date of Birth: ___________________________ Gender: female ______male______

Education: ____

Married: ____ Separated: ____ Divorced: __ Widowed: ____ Single: ____ Partnership: ____

Live with: Spouse _____ Partner _____ Parents _____ Children ____ Friends ____ Alone _____

Occupation: ______________________________ Hours per week: _________Retired: ____

Employer: _____________________________________ S.S.#: ___________________________

(Work address): ____

Who may we thank for referring you to our clinic? ____

Has any other family member already been a patient at the clinic? ______________________________

Next of Kin or other to reach in an emergency: ____

Relationship: _____________________________ Phone: ____________________________

Address: ____

____

Insurance Information:

Company: ____ID #: _____________________

Group #: ____________________Primary Insured if not self: ________________________

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What expectations do you have from **THIS VISIT** to our clinic?

What **LONG TERM** expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits:

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

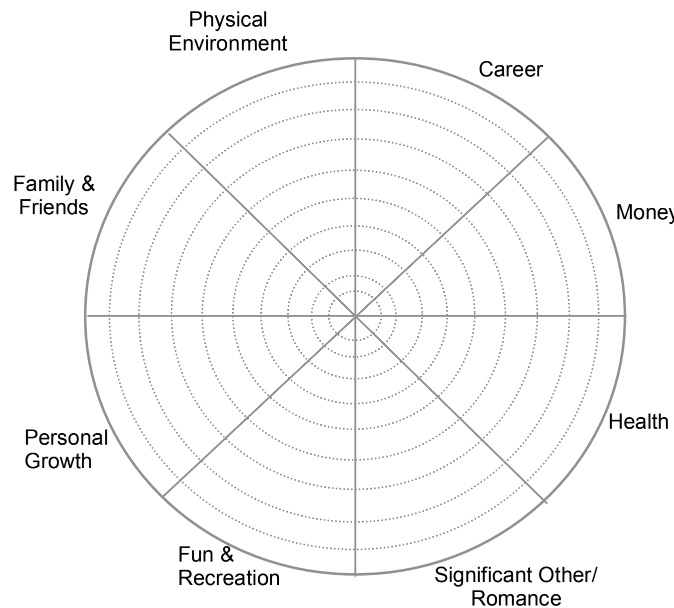
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wheel of Balance

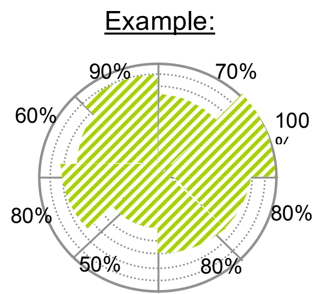
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example:



Are you currently receiving healthcare? Y N

If yes, where and from whom:____

____

If no, when and where did you last receive medical or health care? ____________________________

____

What was the reason? ____

What are your most important health concerns? List as many as you can in order of importance:

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

Do you have any known contagious diseases at this time? Y N If yes, what? _______________________

Have you ever received a blood transfusion? Y N

Family History

Do you have a family history of any of the following?

_____ Cancer	_____ Diabetes	_____ Heart Disease	_____ High Blood Pressure
_____ Kidney Disease	_____ Epilepsy	_____ Arthritis	_____ Glaucoma
_____ Tuberculosis	_____ Stroke	_____ Anemia	_____ Mental Illness
_____ Asthma/Hayfever/Hives			

Any other relevant family history? ____

____

What is your heritage: ____

Childhood Illnesses

Please circle whether you had any of these as a child:

_____ Scarlet fever	_____ Diphtheria	_____ Rheumatic fever
_____ Mumps	_____ Measles	_____ German measles

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_________________________year: ________ _________________________ year: ________

_________________________year: ________ _ _________________________ year: ________

_________________________year: ________ _________________________ year: ________

Allergies

Are you hypersensitive or allergic to...

Any drugs? ____

Any foods? ____

Any environmentals or chemicals? ____

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)______________________________________ 5) ______________________________________

2)______________________________________ 6) ______________________________________

3)______________________________________ 7) ______________________________________

4)______________________________________ 8) ______________________________________

General

Height: _________________Weight:_________________ lbs. Weight 1 year ago: _________lbs.

Maximum Weight : _________________ When: ____

When during the day is your energy the best? _______________ worst? ___________________

Typical Food Intake

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

To drink: ______________________________

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you <u>have now</u> **N=**Never had **P=**<u>Significant</u> problem in the past

Habits

Main interests and hobbies?______________________________

Do you exercise? Y N

If yes, what kind?______________________ How often? ______________

Average 6-8 hrs. sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Have a history of abuse?	Y N	how many hours? _______	
Any major traumas?	Y N P	Read?	Y N
Use recreational drugs?	Y N P	how many hours? ______	
Been treated for drug dependence?	Y N P		
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
Treated for alcoholism?	Y N P	Do you go on diets often?	Y N
Do you use tobacco?	Y N P	Do you eat out often?	Y N
Smoked previously?	Y N P	Do you drink coffee?	Y N P
How many years? ______________		Drink black/green tea?	Y N P
How many packs per day? ______________		Do you drink cola/other sodas?	Y N P
		Do you eat refined sugar?	Y N P
		Do you add salt?	Y N P

Do you have a religious or spiritual practice? Y N If yes, what?______________________

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

Immune

Reactions to immunizations?	Y N P	Reactions to vaccinations?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

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Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	Shortness of breath lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? __________	
Gall Bladder disease?	Y N P	Is this a change?___________	
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

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Male Reproduction

Hernias? Y N P
Testicular pain? Y N P
Venereal disease? Y N P
Are you sexually active? Y N
Sexual orientation: ________________________
Impotence? Y N P
Premature ejaculation? Y N P
Birth control? Type? ______________________

Testicular masses? Y N P
Prostate disease? Y N P
Discharge or sores? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Condyloma? Y N P
Herpes? Y N P
Syphilis? Y N P

Female Reproduction / Breasts

Age of first menses? ________________________
Age of last menses? (if menopausal) _______
Length of cycle? ________________ days
Duration of menses? ________________ days
Painful menses? Y N P
Heavy or excessive flow? Y N P
PMS? Y N P
If yes, what are your symptoms?
____
____
Endometriosis? Y N P
Ovarian cysts? Y N P
Difficulty conceiving? Y N P
Cervical Dysplasia? Y N P
Sexual difficulties? Y N P
Gonorrhea? Y N P
Herpes? Y N P
Are you sexually active? Y N
Do you do breast self exams? Y N P
Breast pain/tenderness? Y N P

Date of last annual exam/ PAP _____________
Are cycles regular? Y N
Bleeding between cycles? Y N P
Pain during intercourse? Y N P
Clotting? Y N P
Discharge? Y N P
Birth control? Y N P
What type? ________________________
Number of pregnancies: ______________
Number of live births: ________________
Number of miscarriages: _____________
Number of abortions: ________________
Menopausal symptoms? Y N P
Abnormal PAP? Y N P
Chlamydia? Y N P
Condyloma? Y N P
Syphilis? Y N P
Sexual orientation: __________________
Breast lumps? Y N P
Nipple discharge? Y N P

Is there anything else you would like to add or comment on?

Thank you for your time and effort.
We look forward to providing you with the best possible care.