

glow

NATURAL HEALTH CENTER, PLLC

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General Information

Patient Name: _____ **Date:** _____

Wellness goals, check those that you are interested in:

- | | | |
|---|---|---|
| <input type="checkbox"/> Improved basic health | <input type="checkbox"/> Emotional well-being | <input type="checkbox"/> Prevent chronic disease |
| <input type="checkbox"/> Eliminate pain | <input type="checkbox"/> Shamanic Healing | <input type="checkbox"/> Reduce drug side effects |
| <input type="checkbox"/> Therapeutic massage | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Hormone balancing |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Improved fitness | <input type="checkbox"/> Supplements for health |
| <input type="checkbox"/> Primary care | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Improved energy | <input type="checkbox"/> Fertility | <input type="checkbox"/> Lab tests |
| <input type="checkbox"/> Supportive cancer care | <input type="checkbox"/> Improved sleep | |
| <input type="checkbox"/> Craniosacral | <input type="checkbox"/> Stress reduction | |

Current Complaint

Main problem(s) you'd like help with. _____

How long ago did this problem begin (month/day /year)? _____

Does this problem interfere with your daily activities (work, sleep, sex)? _____

Problem gets worse with... _____

Problem gets better with... _____

Have you ever been given a diagnosis for this problem? _____

What kinds of treatment have you tried? _____

Past History

Hospitalizations _____

Significant illnesses _____

Significant traumas or injuries _____

Date of last physical exam _____

Please check any condition that applies to you or a family member and include the date(s).

(Self=S, Family=F)

- | | S | F | | S | F |
|------------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|
| Addiction issues | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer's | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Name: _____ Date: _____

What type? _____

- Depression/ Anxiety
- Diabetes
- Edema
- Excema
- Epilepsy
- Headaches
- Heart attack/disease
- Hepatitis
- Herpes

- High blood pressure
- High cholesterol
- HIV
- Kidney disease
- Mental illness
- Osteoporosis
- Stroke
- Thyroid disease
- Tuberculosis

Habits

- Alcohol (per week) _____
- Coffee/tea/ cola (per week) _____
- Soft drinks (per week) _____
- Tobacco (packs per day) _____
- Drugs (for non medical purposes) _____
- Sleep (hours per night) _____
- Water (per day) _____

Have you ever been on a restricted diet? Y/ N What kind? _____

Average daily diet:

Morning	Afternoon	Evening
_____	_____	_____
_____	_____	_____

Do you crave sugar or salty foods? Y/ N

Do you have a regular exercise program? Y/ N If yes, please describe: _____

Do you have a spiritual practice? Y/ N If yes, please describe. _____

Do you have allergies? (food, environmental, drug?) If yes, please list _____

Please list prescription and over the counter medications you are taking.

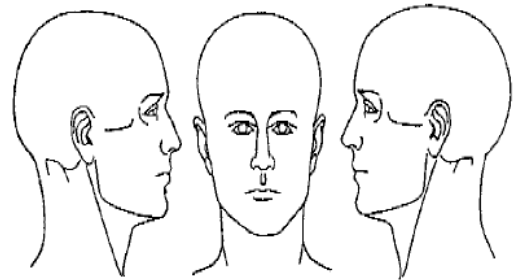
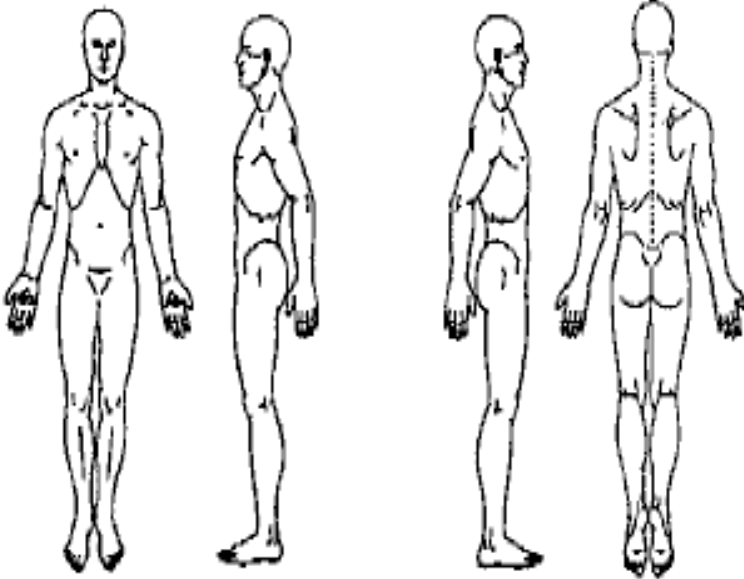
Medication	dose	date started	prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list vitamins, minerals, herbs, and homeopathic remedies you are taking.

Supplement	dose	date started
_____	_____	_____
_____	_____	_____

Please indicate painful or distressed areas:

Pain level (please mark with an X): no pain _____ worst possible pain



Notes:

Review of Systems

Please check following: N=condition you have now, P=condition you've had in the past

	N	P		N	P		N	P
Skin								
Dry	<input type="checkbox"/>	<input type="checkbox"/>	Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Oily	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Styes	<input type="checkbox"/>	<input type="checkbox"/>	Throat/Neck		
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Ears			Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Fungal Infection	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Itch	<input type="checkbox"/>	<input type="checkbox"/>	Mouth		
Slow healing	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Warts	<input type="checkbox"/>	<input type="checkbox"/>	Ringling	<input type="checkbox"/>	<input type="checkbox"/>	Canker sores	<input type="checkbox"/>	<input type="checkbox"/>
Nails Soft <input type="checkbox"/> Break <input type="checkbox"/>			Poor hearing	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Head								
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nose			Respiratory		
Migranes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
TMJ/jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Color: Clear __ Yellow __			Cough	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Green __			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tremors/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Texture: Thin __ Thick __			Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Eyes								
Vision disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular		
			Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
			Infections	<input type="checkbox"/>	<input type="checkbox"/>	Heart racing/pounding	<input type="checkbox"/>	<input type="checkbox"/>

Heart Disease
 Murmur
 Blood Pressure
 High__ Low __
 Cholesterol
 High__ Low __
 Leg Pain__ Cramps __
 Ankle swelling
 Cold Hands__ Feet __

Digestion

Bowel Movement
 X per day:
 1-2__2-3__3-4__4+ __
 X per week:
 1-2__2-3__3-4__4+ __
 Texture:
 Dry__Hard__Loose __
 Stools with
 Mucus __ Blood __
 Hemorrhoids
 Fissures/Fistula
 Stool incontinence
 Liver/

gallbladder disease
 Ulcer
 Heartburn
 Bloating
 Belching
 Gas
 Nausea
 Pain/cramps

Urinary

Difficult urination
 Painful urination
 Incontinence/dribbling
 Blood in urine
 Cloudy urine
 Frequent urination
 Day__ Night__
 Bladder infections

Muscular/Skeletal

Back Pain
 Low Mid Neck
 Pain in muscles
 Pain in joints
 Stiffness/ Swelling

Muscle weakness
 Numbness/Tingling
 Shooting pain
 Paralysis
 Broken bones
 Which? _____
 Sprained joints
 Which? _____
 Foot pain

Energy (Scale of 1-10)

1=worst, 10=best _____
Sleep
 How many hours? _____
 Wake easily? Y / N
 Hard to fall asleep? Y / N
 Wake rested? Y / N
 Snore? Y / N
 Grind teeth Y / N
 Dreams? Y / N

Temperature
 Sensitive to: hot__cold__
 Prefer: inside__outside__

Perspiration

Sweat easily
 Nightsweats
 Appetite: excessive _____
 good__ poor__
 Prefer foods:hot__cold__
 Prefer drinks:hot__cold__
 Thirst: excessive__none__
 Recent weight change _____

Mental/Emotional

Anxiety
 Stress (scale of 1-10
 1=none,10=max) _____
 Depression
 Suicidal thoughts

Women Only

Date of last pelvic exam _____
 Abnormal pap smear
 STD
 Which? _____
 Sexual abuse
 Yeast infections
 Vaginal discharge
 Age of first period _____

Irregular periods
 Flow: heavy__medium__light__
 Length of cycle _____
 Days of flow _____
 Date of last period _____
 Spotting
 Cramps
 PMS Endometriosis
 Cysts Fibroids

Have you ever used
 Birth control pills
 How long?__ When? _____
 Present birth control
 Method? _____

Change in sex drive
 Painful intercourse
 Pregnancies (#) _____
 Children (#) _____

Complications
 Miscarriages (#) _____
 Abortions (#) _____
 Fertility issues
 Hysterectomy
 Age at menopause
 Vaginal dryness
 Hot flashes
 Do you do self breast exams? _____
 Date of last Mammogram? _____

Men Only

Date of last prostate exam _____
 Prostate enlargement
 Change in force of
 urine stream?
 Dribbling
 Difficulty starting and
 stopping urination?
 Pain in scrotum
 Painful intercourse
 Difficult erections
 Change in sex drive
 STD
 Which? _____
 Sexual abuse
 Fertility issues
 Discharge from penis