

GIG HARBOR NATUROPATHIC MEDICINE PS

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CONFIDENTIAL PATIENT INFORMATION

NAME _____ SEX _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (PRIMARY) _____ (WORK) _____ MARITAL STATUS: S M W D

MAY WE LEAVE A MESSAGE ON YOUR PRIMARY PHONE? YES NO ON YOUR WORK PHONE? YES NO

AGE _____ BIRTHDATE ____/____/____ HOW MANY CHILDREN? _____

OCCUPATION _____

NAME IN CASE OF EMERGENCY _____ PHONE _____

WHAT OTHER HEALTH CARE ARE YOU PRESENTLY RECEIVING? _____

DATE OF LAST PHYSICAL EXAM? _____ WHERE? _____

WHERE DID YOU HEAR ABOUT OUR CLINIC? _____

PRESENT HEALTH CONCERNS: IN YOUR OPINION, WHAT ARE YOUR MOST IMPORTANT HEALTH CONCERNS IN THEIR ORDER OF SIGNIFICANCE? PLEASE INDICATE THE PROBLEM THAT MOTIVATED YOU TO COME IN TODAY.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATIONS: SUPPLEMENTS, PRESCRIPTION & NON-PRESCRIPTION DRUGS.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

INSURANCE INFORMATION: PLEASE PRESENT INSURANCE CARD FOR OUR RECORDS

INSURANCE COMPANY _____

ID # _____ GROUP# _____

INSURED NAME _____ RELATIONSHIP _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT GHNM, PS WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME THAT MY INSURANCE CARRIER DOES NOT COVER I AM PERSONALLY RESPONSIBLE TO PAY. PAYMENT IS EXPECTED AT TIME OF VISIT.

PATIENT SIGNATURE _____ DATE ____/____/____

PARENT OR GUARDIAN SIGNATURE _____

YOUR HEALTH HISTORY

HOW WAS YOUR HEALTH AS A CHILD? GOOD FAIR POOR

CHILDHOOD ILLNESSES: SCARLET FEVER WHOOPING COUGH MEASLES CHICKEN POX

HOSPITALIZATIONS (YEAR & REASON) _____

SURGERIES (YEAR & TYPE) _____

SERIOUS ILLNESSES OR INJURY (YEAR & CAUSE) _____

VACCINATIONS: UP-TO-DATE PARTIAL ADVERSE REACTION

ALLERGIES: LIST ANY ALLERGIES YOU HAVE TO:

DRUGS: _____

FOODS: _____

OTHER: _____

WHAT HAPPENS WHEN YOU HAVE AN ALLERGY ATTACK? _____

HABITS: CIRCLE ALL THAT APPLY: ALCOHOL TOBACCO CAFFEINE RECREATIONAL DRUGS

DIET: ARE YOU SATISFIED WITH YOUR DIET AS IT IS NOW? YES NO

WHAT FOODS DO YOU CRAVE? CIRCLE ALL THAT APPLY: CARBOHYDRATES SWEETS SALTY FATS

ANY DIET RESTRICTIONS OR REGIMEN? DESCRIBE: _____

SLEEP: DO YOU: SLEEP WELL? YES NO WAKE RESTED? YES NO AVG HRS OF SLEEP _____

EXERCISE: YES NO WHAT TYPE? _____

HOW MANY HOURS A WEEK? _____

FAMILY MEDICAL HISTORY

PLEASE LIST ANY PERTINENT HEALTH HISTORY FOR YOUR FAMILY: ECZEMA, ASTHMA, HEART DISEASE, CANCER, DIABETES, ANXIETY, DEPRESSION, MENTAL HEALTH ISSUES, LEARNING DISABILITIES, AUTOIMMUNE DISEASES, DIGESTIVE ISSUES, PSORIASIS, PARKINSONS, ETC.

MOM: _____

MATERNAL GMA: _____

MATERNAL GPA: _____

DAD: _____

PATERNAL GPA: _____

PATERNAL GMA: _____

BROTHERS: _____

SISTERS: _____

CHILDREN: _____

REVIEW OF SYSTEMS

Please circle the following: Y=a condition you have now. P=a condition you have had in the past. N=never had

CIRCULATION

Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N

NEUROLOGIC

Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness	Y	P	N
Loss of memory	Y	P	N

ENDOCRINE

Thyroid problem	Y	P	N
Heat/cold intolerance	Y	P	N
Hypoglycemia	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Easy weight gain	Y	P	N

Female Reproduction

Age menses began _____

of days menstrual flow _____

Length of cycle _____

Bleeding between periods	Y	P	N
Are cycles regular?	Y	P	N
Pain during intercourse	Y	P	N
Cramps	Y	P	N
Abnormal vag. discharge	Y	P	N
Excessive flow	Y	P	N
PMS	Y	P	N

Date of last Pap smear _____

Abnormal results	Y	P	N
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Date of last period _____

of pregnancies _____

of live births _____

of miscarriages _____

Type of birth control _____

Difficulty conceiving	Y	P	N
Menopausal symptoms	Y	P	N
Are you sexually active?	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N

BREASTS

Regular self exams?	Y	P	N
Lumps	Y	P	N
Pain or tenderness	Y	P	N
Nipple discharge	Y	P	N

EMOTIONAL

Depression	Y	P	N
Mood Swings	Y	P	N
Anxiety/nervousness	Y	P	N
Tension	Y	P	N

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N
Broken bones	Y	P	N
Muscle spasms/cramps	Y	P	N
Weakness	Y	P	N

Male Reproduction

Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Are you sexually active?	Y	P	N
Sexual difficulties	Y	P	N
Prostate problems	Y	P	N
Venereal disease	Y	P	N
Discharge or sores	Y	P	N
Difficulty starting or stopping urination	Y	P	N
Birth control	Y	P	N

What type? _____

Indicate on Diagram any problem areas:

REVIEW OF SYSTEMS

Please circle the following: Y=a condition you have now. P=a condition you have had in the past. N=never had

GENERAL

Weight _____
 Weight 1 year ago _____
 Maximum weight _____
 When _____
 Height _____
 Night sweats Y P N
 Fatigue Y P N
 Insomnia Y P N

SKIN

Rashes Y P N
 Inflammation Y P N
 Infection Y P N
 Growths Y P N
 Chng in hair/nail Y P N

HEAD

Headaches Y P N
 Head injury Y P N

EYES

Impaired vision Y P N
 Eye pain Y P N
 Tearing or dry Y P N
 Double vision Y P N

EARS

Impaired hearing Y P N
 Ringing Y P N
 Earache/itch Y P N
 Dizziness Y P N

NOSE & SINUS

Frequent colds Y P N
 Nose bleeds Y P N
 Stuffiness Y P N
 Sinus problems Y P N
 Post nasal drip Y P N

MOUTH & THROAT

Freq sore throat Y P N
 Sore tongue Y P N
 Sores mouth/lip Y P N
 Gum problem Y P N
 Hoarseness Y P N
 Dental problems Y P N

BLOOD

Anemia Y P N
 Easy bleeding or buising Y P N

RESPIRATORY

Cough Y P N
 Spitting up blood Y P N
 Wheezing Y P N
 Difficulty breathing Y P N
 Pain on breathing Y P N
 Shortness of breath Y P N
 “ lying down Y P N
 “ at night Y P N
 Postitive TB test Y P N

HEART

Heart disease Y P N
 High blood pressure Y P N
 Rheumatic fever Y P N
 Chest pain Y P N
 Swelling in ankles Y P N
 Palpitations, fluttering Y P N

DIGESTION

Trouble swallowing Y P N
 Heartburn Y P N
 Stomach pain Y P N
 Change in thirst Y P N
 Change in appetite Y P N
 Nausea Y P N
 Vomitting Y P N
 Bowels move daily more less
 Loose stools Y P N
 Is this a change Y P N
 Blood in stools Y P N
 Belching or gas Y P N
 Liver/gallbladder disease Y P N
 Hemorrhoids Y P N

URINARY

Pain on urination Y P N
 Increase frequency Y P N
 Frequency at night Y P N
 Inability to hold urine Y P N
 Bladder infections Y P N