GIG HARBOR NATUROPATHIC MEDICINE PS

DR. LESLIE CHARLES

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?

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 ALLERGIC REACTION? __________________________________
____

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 : **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
SKIN CHANGES	Y	P	N
SKIN CANCER	Y	P	N
CHANGES IN HAIR	Y	P	N
CHANGES IN NAILS	Y	P	N

HEAD

HEADACHES	Y	P	N
HEAD INJURY	Y	P	N

EYES

IMPAIRED VISION	Y	P	N
EYE PAIN	Y	P	N
ITCHING	Y	P	N
DRY EYE	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
ALLERGIES	Y	P	N
SINUS ISSUES	Y	P	N
NOSE BLEEDS	Y	P	N
POST NASAL DRIP	Y	P	N

MOUTH & THROAT

FREQ SORE THROAT	Y	P	N
CHANGES IN TASTE	Y	P	N
COLD SORES	Y	P	N
CANCRE SORES	Y	P	N
GUM PROBLEMS	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

REVIEW OF SYSTEMS

PLEASE CIRCLE : **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: ___________________

DATE OF LAST PERIOD: ________________

LENGTH OF CYCLE: ____________________

DAYS OF BLEEDING: ___________________

ARE CYCLES REGULAR?	Y	P	N
ARE CYCLES HEAVY?	Y	P	N
DO YOU HAVE CRAMPS?	Y	P	N
PMS?	Y	P	N
SEXUAL DIFFICULTIES?	Y	P	N
ABNORMAL DISCHARGE?	Y	P	N
MENOPAUSAL SYMPTOMS	Y	P	N
ARE YOU SEXUALLY ACTIVE?	Y	P	N
VENEREAL DISEASE	Y	P	N

DATE OF LAST PAP SMEAR ___________

ABNORMAL RESULTS	Y	P	N

OF PREGNANCIES: __________

OF LIVE BIRTHS: ___________

TYPE OF BIRTH CONTROL: _______________

____

DIFFICULTY CONCEIVING	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/NERVOUS	Y	P	N
TENSION	Y	P	N

MUSCULOSKELETAL

JOINT PAIN/STIFFNESS	Y	P	N
BROKEN BONES	Y	P	N
MUSCLE SPASMS	Y	P	N
WEAKNESS	Y	P	N

MALE REPRODUCTION

HERNIAS	Y	P	N
TESTICULAR MASSES	Y	P	N
TESTICULAR PAIN	Y	P	N
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: