Rogue Valley Natural Medicine

Holistic Health Services

Welcome to our clinic! Here's a checklist to help get you ready for your first visit:

_ New patient paperwork filled out.

_ Bring all the supplements/medications that you are currently taking.

_ Women please wear pants (no skirts) to your visits.

_ Avoid wearing perfumes, essential oils, scented hair products, scented lotions.

The first visit will be approx *one hour and 30 minutes.* Please arrive 10 minutes before your scheduled time.

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Intake Form

Name:_____ **Date:**_____
Address:_____
City:_____ **State:**_____ **Zip:**_____
Telephone (home):_____ **(work/cell):**_____
Email address:_____
Age:_____ **Date of Birth:**_____ **Gender: Female / Male**
_ Married _ Separated _ Divorced _ Widowed _ Single _ Partnership
Live with: _ Spouse _ Partner _ Parents _ Children _ Friends _ Alone
Occupation:_____ **Hours per week:**_____
Employer:_____
How did you hear about this Clinic? _____
Emergency contact:_____ **Relationship:**_____
Phone:_____

Health History Questionnaire

What are your most important health problems? List in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Family History

Do you have a family history of any of the following? (Please check)

_ Cancer	**_ Stroke**	**_ High Blood pressure**
_ Kidney Disease	**_ Hay Fever**	**_ Mental Illness**
_ Asthma	**_ Heart Disease**	**_ Glaucoma**
_Tuberculosis	**_ Arthritis**	**_ Hypothyroidism**
_ Diabetes	**_ Anemia**	**_ Depression/Anxiety**
_ Epilepsy	**_ Hives**	**_ Alcoholism**

Hospitalizations/Surgery/Accidents

What hospitalizations or surgeries have you had?

_____ **year:**_____
_____ **year:**_____
_____ **year:**_____

List any accidents:

_____ **year:**_____
_____ **year:**_____
_____ **year:**_____

List any broken bones and dislocations:

_____

Were you ever knocked unconscious? Y N
Have you ever had a lapse of memory? Y N

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Patient Evaluation Questionnaire

1. Please rate on scale how serious you are about getting well (circle number).

0 1 2 3 4 5 6 7 8 9 10
Not Serious Very Serious

2. Would you prefer: (Please Check)
_ Correction of Cause of Health Problems
_ Temporary Symptom Relief

3. Are you willing to follow a treatment program designed to help you return to health? (Treating the Cause)
_ Yes
_ No

4. Are you willing to take nutritional and/or homeopathic supplements?
_ Yes
_ No

5. Are you willing to make dietary changes?
_ Yes
_ No

6. Are you willing to start a moderate exercise program?
_ Yes
_ No

7. Please rate on scale how serious you are about staying healthy after your initial intensive care.

0 1 2 3 4 5 6 7 8 9 10
Not Serious Very Serious

8. Are you familiar with Applied Kinesiology?
_ Yes
_ No
_ Very little (somewhat)
If yes, how were your results? _____

10. Please rate your stress on scale.

0 1 2 3 4 5 6 7 8 9 10
No Stress Total Stress

11. Are any other doctors or practitioners currently treating you?
_ Yes
_ No

If yes, please list _____

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Toxic Profession Past of Present

(Artist, graphic designer, dental asst, gas station worker, painter, industry, cleaners, etc.)

_____ **Age:** _____

_____ **Age:** _____

_____ **Age:** _____

Major Psychological Trauma

_____ **Age:** _____

_____ **Age:** _____

_____ **Age:** _____

Serious Infections/Diseases

(pneumonia, mono, TB, cancer, heart attack, stroke, hepatitis, etc)

_____ **Age:** _____

_____ **Age:** _____

_____ **Age:** _____

Long periods on prescriptions or street drugs

_____ **Age:** _____

_____ **Age:** _____

_____ **Age:** _____

Long visits or lived in a foreign country like India, Mexico, Africa, etc.

_____ **Age:** _____

_____ **Age:** _____

_____ **Age:** _____

Treated for parasites, infection? Y N

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmentals? _____

Current Medications

_ Laxatives
_ Cortisone
_ Tranquilizers
_ Pain relievers
_ Appetite suppressants
_ Thyroid medication
_ Birth control pills
_ Antacids
_ Sleeping pills
_ Antibiotics

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

_____

_____

_____

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Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____

Habits

Main interests and hobbies _____
_____
Do you exercise? Y N
If yes, what kind? _____ **How often?** _____
Average 7-8 hrs sleep? Y N
Sleep Well? Y N
Awaken rested? Y N
When during the day is your energy the best? _____ **Worst?** _____
Have a supportive Relationship? Y N
Have a history of Abuse? Y P N
Use Recreational drugs? Y P N
Do you eat three meals a day? Y N
Do you eat out often? Y N
Do you drink coffee? Y N
Do you drink black/green/herbal teas? Y N
Enjoy your work? Y N
Take vacations? Y N
Spend time outside? Y N
Watch television? Y N How many hours per day? _____
Alcoholic beverages? Y P N How many drinks per week? _____
Smoke? Y P N How much per day? _____ **How many years?** _____
Do you have a religious or spiritual practice? Y N
If yes, what? _____

How does your condition affect you? _____
_____
_____
What do you think is happening? _____
_____
_____
Why? _____
_____
_____
_____
What do you feel needs to happen for you to get better? _____
_____
_____
_____
How long do you think it will take for you to get better? _____
_____

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Review of symptoms

Y = a condition you have now N= never had P= a condition you have had before

Appendicitis	Y P N	Chicken Pox	Y P N
Polio	Y P N	Alcoholism	Y P N
Whooping cough	Y P N	Epilepsy	Y P N
Anemia	Y P N	HIV	Y P N
Measles	Y P N	Multiple Sclerosis	Y P N
Mumps	Y P N		

General

Chills	Y P N	Loss of Sleep	Y P N
Convulsions	Y P N	Loss of Weight	Y P N
Fainting	Y P N	Neuralgia	Y P N
Fatigue	Y P N	Sweats	Y P N
Fever	Y P N		

Mental/Emotional

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

Endocrine

Hypothyroid	Y P N	Diabetes	Y P N
Hypoglycemia	Y P N	Excessive hunger	Y P N
Excessive thirst	Y P N	Seasonal depression	Y P N
Fatigue	Y P N	Night sweats	Y P N
Heat or Cold intolerance	Y P N		

Immune

Chronic fatigue Syndrome	Y P N	Reactions to vaccinations	Y P N
Chronic swollen glands	Y P N	Chronic infections	Y P N
		Slow wound healing	Y P N

Neurologic

Seizures	Y P N	Numbness or tingling	Y P N
Muscle weakness	Y P N	Easily stressed	Y P N
Loss of Memory	Y P N	Loss of Balance	Y P N
Vertigo or dizziness	Y P N	Fainting	Y P N
Paralysis	Y P N		

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Skin

Rashes	Y P N	Lumps	Y P N
Eczema or Hives	Y P N	Itching	Y P N
Acne/Boils	Y P N	Hair loss	Y P N
Color change	Y P N	Bruises easily	Y P N

Head Eyes Ears Nose Throat

Headaches	Y P N	Dizziness	Y P N
Migraines	Y P N	Frequent colds	Y P N
Head injury	Y P N	Stuffy nose	Y P N
Jaw/TMJ problems	Y P N	Runny nose	Y P N
Spots in eyes	Y P N	Sinus problems	Y P N
Impaired vision	Y P N	Nose bleeds	Y P N
Blurriness	Y P N	Hay fever	Y P N
Color blindness	Y P N	Loss of smell	Y P N
Double vision	Y P N	Frequent sore throat	Y P N
Cataracts	Y P N	Teeth grinding	Y P N
Glasses and/or contacts	Y P N	Gum problems	Y P N
Eye pain/strain	Y P N	Dental cavities	Y P N
Tearing or dryness	Y P N	Sores on tongue or lips	Y P N
Glaucoma	Y P N	Hoarseness	Y P N
Impaired hearing	Y P N	Difficulty swallowing	Y P N
Ear aches	Y P N	Goiter	Y P N
Ringing in the ears	Y P N	Swollen glands	Y P N

Respiratory

Cough	Y P N	Shortness of breath	Y P N
Persistent cough	Y P N	Shortness of breath at night	Y P N
Spitting up blood	Y P N	Tuberculosis	Y P N
Asthma	Y P N	Spitting up phlegm	Y P N
Pneumonia	Y P N	Wheezing	Y P N
Emphysema	Y P N	Bronchitis	Y P N
Pain on breathing	Y P N		

Cardiovascular

Heart disease	Y P N	Varicose veins	Y P N
High blood pressure	Y P N	Murmurs	Y P N
Low blood pressure	Y P N	Blood clots	Y P N
Pain over heart	Y P N	Phlebitis	Y P N
Poor circulation	Y P N	Rheumatic fever	Y P N
Rapid heart	Y P N	Swelling in ankles	Y P N
Slow heart beat	Y P N	Palpitations/fluttering	Y P N
Stroke	Y P N		

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Gastrointestinal

Trouble swallowing	Y P N	Heart burn	Y P N
Change of thirst	Y P N	Change in appetite	Y P N
Nausea	Y P N	Constipation	Y P N
Vomiting blood	Y P N	Diarrhea	Y P N
Blood in stool	Y P N	Gallbladder trouble	Y P N
Abdominal pain/cramps	Y P N	Ulcer	Y P N
Belching or passing gas	Y P N	Hemorrhoids	Y P N
Black stools	Y P N	Poor appetite	Y P N
Liver trouble	Y P N	Poor digestion	Y P N

Bowel movements: How often? _____ Is this a change? Y N

Urinary

Pain on urination	Y P N	Kidney stones	Y P N
Frequency at night	Y P N	Blood in urine	Y P N
Frequent infections	Y P N	Kidney infection	Y P N
Increased frequency	Y P N	Prostate trouble	Y P N
Inability to hold urine	Y P N		

Male Reproduction

Hernias	Y P N	Premature ejaculation	Y P N
Testicular pain	Y P N	Testicular masses	Y P N
Venereal disease	Y P N	Prostate disease	Y P N
Impotence	Y P N	Discharge or sores	Y P N

Female Reproduction/Breasts

Age of first menses _____		Discharge	Y P N
Age of last menses _____		Herpes	Y P N
Length of cycle _____ days		Venereal disease	Y P N
Duration of menses _____ days		IUD	Y P N
Painful menses	Y P N	Birth control	Y P N
Heavy of excessive flow	Y P N	What type? _____	
PMS	Y P N	Number of pregnancies _____	
If yes, what are your symptoms? _____		Number of live births _____	
_____		Number of miscarriages _____	
Endometriosis	Y P N	Number of abortions _____	
Ovarian cysts	Y P N	Hot flashes	Y P N
Difficulty conceiving	Y P N	Lump in breast	Y P N
Are cycles regular?	Y P N	Have you had a mammogram?	Y N
Bleeding between cycles	Y P N	Last Pap smear date: _____	
Pain during intercourse	Y P N	Was it normal?	Y N
Clotting	Y P N		

Muscles/Joints/bones

Backache	Y P N	Stiff neck	Y P N
Foot trouble	Y P N	Swollen joints	Y P N
Pain trouble	Y P N	Tremors/twitching	Y P N
Shoulders	Y P N	Arm trouble	Y P N
Painful tail bone	Y P N		

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If you have musculoskeletal pain, please complete the following:

Please mark the **intensity** of your pain today: 0 = no pain to 10 = intense pain

Area: _____ Intensity: _____
Area: _____ Intensity: _____
Area: _____ Intensity: _____
Area: _____ Intensity: _____

How long has this condition lasted? _____

Is this condition: _ Getting worse _ The same _ Improving

Was this caused by an injury/accident? _ Y _ N
If no, when did you first notice it? _____

Pain came on: _ Gradually _ Suddenly

The pain is: _ Occasional _ Frequent _ Constant

Describe the pain: _ Sharp (knife-like) _ Dull (toothache) _ Burning (hot)

Does the pain: _ Stay in one spot _ Radiate (shoots) _ Goes up and down the spine

What time is the pain worst: _ Morning _ Afternoon _ Evening _ Night _ All the time

Do you have pain in: _ Legs _ Feet _ Arms _ Hands _ Left _ Right

Numbness or tingling in: _ Legs _ Feet _ Arms _ Hands _ Left _ Right
What makes the pain worse? _____
What makes the pain better? _____

Does the pain affect you sleeping: _ No _ Occasionally _ Frequently _ Constantly

Does the pain affect your work: _ No _ Occasionally _ Frequently _ Constantly

Have you been hospitalized in the past five years? _ Yes _ No
If yes, for what? _____

Have you had major surgery in the past five years? _ Yes _ No
If yes, for what? _____

Have you had other doctors for this condition? _ Yes _ No
If yes, doctor(s)' name(s)

_____