Whole Health Clinic

6632 S. 191st Place, Suite E-110; Kent, WA 98032
(425) 656-0700 – Fax (425) 656-0705

Date: _____

Name:_____ Age:_____ Birth Date: _____ Gender at birth: M F

Address:_____City _____State _____ Zip:_____

Phone: Home _____ Can messages be left for you here? Y N

Work _____ Can messages be left here? Y N

Cell _____ Can messages be left here? Y N

Email:_____ Would you like to receive notices from our office? _____

Occupation:_____ Employer: _____

Single or Married? _____

Name of Emergency Contact: _____ Phone: _____(Home)/(cell)

How did you hear about us? _____

Insurance information: Name of the insurance company? _____

Subscriber's name (this could be you or your partner)? _____

Subscriber's employer? _____

Subscriber's date of birth? _____

Present Health Concerns: Please list your most important health concerns in their order of significance.

Problem or diagnosis #1) _____

When did this problem initially start to bother you? _____

How often does it bother you- hourly, daily, weekly, monthly? _____

How severe on a scale of zero to 10 (10 being the worse/highest level)? _____

What makes this problem better or worse, namely drugs or supplements, etc.? _____

Anything else important about this problem you'd like to share? _____

Problem or diagnosis #2) _____

When did this problem initially start to bother you? _____

How often does it bother you- hourly, daily, weekly, monthly? _____

How severe on a scale of zero to 10 (10 being the worse/highest level)? _____

What makes this problem better or worse, namely drugs or supplements, etc.? _____

Anything else important about this problem you'd like to share? _____

Problem or diagnosis #3) _____

When did this problem initially start to bother you? _____

How often does it bother you- hourly, daily, weekly, monthly? _____

How severe on a scale of zero to 10 (10 being the worse/highest level)? _____

What makes this problem better or worse, namely drugs or supplements, etc.? _____

Anything else important about this problem you'd like to share? _____

Problem or diagnosis #4) _____

When did this problem initially start to bother you? _____

How often does it bother you- hourly, daily, weekly, monthly? _____

How severe on a scale of zero to 10 (10 being the worse/highest level)? _____

What makes this problem better or worse, namely drugs or supplements, etc.? _____

Anything else important about this problem you'd like to share? _____

Problem or diagnosis #5) _____

When did this problem initially start to bother you? _____

How often does it bother you- hourly, daily, weekly, monthly? _____

How severe on a scale of zero to 10 (10 being the worse/highest level)? _____

What makes this problem better or worse, namely drugs or supplements, etc.? _____

Anything else important about this problem you'd like to share? _____

Problem or diagnosis #6) _____

When did this problem initially start to bother you? _____

How often does it bother you- hourly, daily, weekly, monthly? _____

How severe on a scale of zero to 10 (10 being the worse/highest level)? _____

What makes this problem better or worse, namely drugs or supplements, etc.? _____

Anything else important about this problem you'd like to share? _____

If you have other problems you'd like to share with us, please type them up on a separate sheet of paper in the same format as above.

Please list any prescription or over the counter medications that you are currently taking:

Name of DRUG	Dose	Reason for taking	For how long	Who prescribed

ALLERGIC TO ANY DRUGS OR SUBSTANCES? WHAT? _____

Please list any vitamins, minerals, herbs or homeopathic remedies that you are presently taking:

Name of **SUPPLEMENT**	Dose	Reason for taking	For how long	Who prescribed

Please list your current health care providers:

Name	Type	For what reason	Phone (if available)

Hospitalizations, Serious Illnesses and Injuries: (Please list reason and dates, excluding non-surgical childbirth)

_____

Date of last full physical exam: _____ Results: normal other _____

Date of last blood work: _____ Results: normal other _____

(Females) Are you pregnant, or is there any *chance* that you are pregnant? _____

Do you have any surgical implants? If so, what type and where in your body? _____

Have you seen a naturopath before? _____ If so, how many other naturopaths have you seen? _____

How long have you been interested in natural medicine? _____

Lifestyle Habits:

Tobacco (currently):None Daily Weekly Monthly Amount? _____

Do you any history of smoking? If so, how many years? What years? _____

Coffee: None Daily Weekly Monthly Amount? _____

Black tea: None Daily Weekly Monthly Amount? _____

Soft drinks: None Daily Weekly Monthly Amount? _____

Alcohol: None Daily Weekly Monthly Amount? _____

History of significant alcohol consumption or alcoholism? _____ How long and how much? _____

Recreational drugs: None Daily Weekly Monthly Amount? _____

History of significant recreational drug use? _____

Exercise: None Daily Weekly Monthly Amount? _____

Are you currently sexually active? _____ How do you rate your libido on a scale of 0-10 (optional)? _____

Diet:

Please describe your typical diet (breakfast, lunch, and dinner), including any guidelines or restrictions that you follow:

Breakfast:

Lunch:

Dinner:

Do you have a gas stove or electric stove at home? _____
How often do you eat fish (How many times per week or per month)?_____
Do you have a sweet tooth?_____
Do you chew gum often, and how often? _____
Do you use artificial sweeteners such as Splenda? Which ones? _____

(Optional) Please describe briefly your religious and/or spiritual background/beliefs:_____

SEAM Questions (Sleep, Energy, Appetite, and Mood)

Sleep:

Hours of sleep per night? _____
Any problems with sleep?_____
How often in a week do you wake up feeling refreshed? _____

Energy:

Energy level on a scale of 1-10 (1 is you cannot get up,10 is optimal full energy)?_____

Appetite:

How is your appetite on a scale of 0-10? (zero is you have no appetite, 10 is voracious appetite)? _____

Mood:

How would you describe your day-to-day mood?

What is your overall sense of well-being? _____

PATIENT PROFILE (PLEASE ANSWER CAREFULLY.)

REVIEW OF SYSTEMS: **Y = Now** **P = Past**

For the following, PLEASE CIRCLE, or fill in blanks. "Y" means you have the condition now. "P" means that you had the condition in the past, but not any more. If you have never had a condition, leave it blank.

GENERAL
- Height _____
- Weight _____
- Weight changes Y P
- Night Sweats Y P
- Fatigue Y P
- Fever Y P

SKIN
- Acne Y P
- Eczema Y P
- Hives Y P
- Rashes Y P
- Infection Y P
- Growths (such as warts) Y P
- Changes in hair/nails Y P
- Transdermal skin patches? _____

HEAD
- Headache Y P
- Head Injury Y P

EYES
- Dryness Y P
- Glasses or contacts Y P
- Eye pain Y P
- Tearing Y P
- Double vision Y P

EARS
- Impaired hearing Y P
- Ringing (tinnitus) Y P
- Ear ache/itch Y P
- Dizziness Y P

NOSE & SINUSES
- Frequent colds Y P
- Nose bleeds Y P
- Stuffiness Y P
- Sinus problems Y P
- Post nasal drip Y P

MOUTH & THROAT
- Frequent sore throat Y P
- Sore tongue Y P
- Sores in mouth /on lips Y P
- Gum problems Y P
- Hoarseness Y P
- Dental Problems Y P
- Fake teeth? How many?
- How many amalgam (mercury) fillings?
- Dental implants?
  - If yes, what type?
- Dental bridges or partial bridges?
  - If so, are they metallic?
- Any metal of any kind in your mouth?

MENTAL / EMOTIONAL
- Depression Y P
- Mood Swings Y P
- Anxiety or nervousness Y P
- Tension Y P
- Suicide thoughts Y P
- Suicide attempts Y P

ENDOCRINE
- Ever had any thyroid problem Y P
- Heat or cold intolerance Y P
- Hypoglycemia Y P
- Excessive thirst Y P
- Excessive hunger Y P
- Easy weight gain Y P

CIRCULATION
- Deep leg pain Y P
- Cold hands/ feet Y P
- Varicose veins Y P

BLOOD
- Anemia Y P
- Easy bleeding or bruising Y P

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

RESPIRATORY

Cough	Y	P
Spitting up blood	Y	P
Wheezing	Y	P
Difficulty breathing	Y	P
Shortness of breath	Y	P
Positive TB test ever?	Y	P

DIGESTION

Trouble swallowing	Y	P
Heartburn	Y	P
Take heartburn or acid reflux medicines?		
Bloating after eating	Y	P
Change in appetite	Y	P
Change in thirst	Y	P
Loose stools	Y	P
Blood in stools	Y	P
Belching or gas	Y	P
Liver/gall bladder disease	Y	P
Hemorrhoids	Y	P
Nausea	Y	P
Vomiting	Y	P

Bowels move: daily more less

Use laxatives? What kind?

Eat plenty of fiber?

URINARY

Pain on urination	Y	P
Increased frequency	Y	P
Frequency at night	Y	P
Inability to hold urine	Y	P
Bladder infections	Y	P
Swellings anywhere in body	Y	P

MUSCULOSKELETAL

Joint pain or stiffness	Y	P
Broken bones	Y	P
Muscle spasms or cramps	Y	P
Muscle spasms or cramps	Y	P
Weakness	Y	P

Date of last DEXA scan?

NEUROLOGIC

Fainting	Y	P
Seizures	Y	P
Paralysis	Y	P
Muscle weakness	Y	P
Numbness or tingling	Y	P
Loss of memory	Y	P

NECK

Swollen glands	Y	P
Pain or stiffness	Y	P

MALE

Hernias	Y	P
Testicular masses	Y	P
Testicular pain	Y	P
Discharge or sores	Y	P
Venereal disease	Y	P
Difficulty stopping or starting urination	Y	P
Prostate problems	Y	P

Date of last prostate exam _____

FEMALE

Age menses began _____

No. of days menstrual flow _____

Length of complete cycle _____

Are cycles regular	Y	P
Bleeding between periods	Y	P
Excessive flow	Y	P
Cramps	Y	P
PMS	Y	P
Abnormal vaginal discharge	Y	P

DATE of LAST PAP Smear _____

Results were: normal abnormal don't know

EVER had an abnormal PAP? Y P

Date of last mammogram? _____

Ever used birth control pills? Y P

Ever used an IUD? Y P

If so, how long? _____

No. of pregnancies _____

No. of live births _____

No. of miscarriages _____

No. of abortions _____

Menopausal symptoms Y P

Still have your own uterus? Yes or No?

Still have your own ovaries? Yes or No?

BREASTS

Do you self exam regularly	Y	P
Lumps	Y	P
Pain or tenderness	Y	P
Nipple Discharge	Y	P

Family History: Please check the boxes below for each condition that applies to one of your family members.

	Mother	Father	Brother	Sister	Grandparent
Alcoholism					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Mental Illness					
Stroke					
Other significant disease(s)					

Circle all the diseases/disorders/conditions that apply, and then specify "Now" or "Past". If both "Now" or "Past" apply, then check both columns.

Conditions/diseases	**NOW**	**PAST**
Acid reflux		
Allergies		
Anemia		
Arthritis, Rheumatoid		
Arthritis, Osteoarthritis		
Asthma		
Atherosclerosis		
ADD or ADHD		
Autoimmune diseases(s)? Which one(s)? (Lupus, MS, RA, myositis, sarcoidosis, etc.)		
Bladder infection		
BPH (Benign Prostatic Hyperplasia)		
Bronchitis		
Cancer, specify type(s)		

Conditions/diseases	NOW	PAST
Cholesterol, high or low?		
Constipation		
Crohn's disease		
Diabetes type 1 or 2		
Diarrhea		
Diverticulitis/Diverticulosis		
Endometriosis		
Fibromyalgia		
Fibrocystic Breasts		
Heavy metal toxicity		
Hepatitis, specify type(s)		
Herpes		
High blood pressure (hypertension)		
Hyperthyroidism		
Hypoglycemia		
Hypothyroidism		
IBS		
IBD (Crohn's or Ulcerative colitis)		
Immune system malfunction (poor immune function, etc.)		
Insomnia		
Interstitial cystitis		
Libido (sex drive), low or high		
Kidney stones		

Conditions/diseases	NOW	PAST
Liver problems (fatty liver, enlarged liver, etc.)		
Memory loss or poor memory		
Menopausal symptoms (hot flashes, sweats, etc.)		
Menstrual problems (painful periods, bloating, etc.)		
Migraine headaches		
Obesity		
Osteopenia		
Osteoporosis		
Ovarian cysts		
PMS		
Prostatitis		
Psoriasis		
Restless legs syndrome		
Sciatica		
Shingles		
Sinusitis		
Tachycardia		
Triglycerides, high		
Tuberculosis		
Tumors, benign or malignant?		
Ulcerative colitis		
Uterine fibroids		
Ulcers		
Yeast infections, vaginal or gastrointestinal?		