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: M F

Address:_____City _____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? _____ Social Security Number: _____

Name of Emergency Contact: _____ Phone: _____(H)/(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.

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

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

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?		