Medicine Naturally
Integrative practice for children and women
922 S Cowley St, Ste 7, Spokane WA 99202
Ph: (509)262-8145 / www.medicine-naturally.com

ADULT INTAKE

Name: _____ Date: _____

How did you hear about this clinic?

Another practitioner_____ Friend/family member Google search

Other_____ (Please specify)

Has any other family member already been a patient at this clinic? _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

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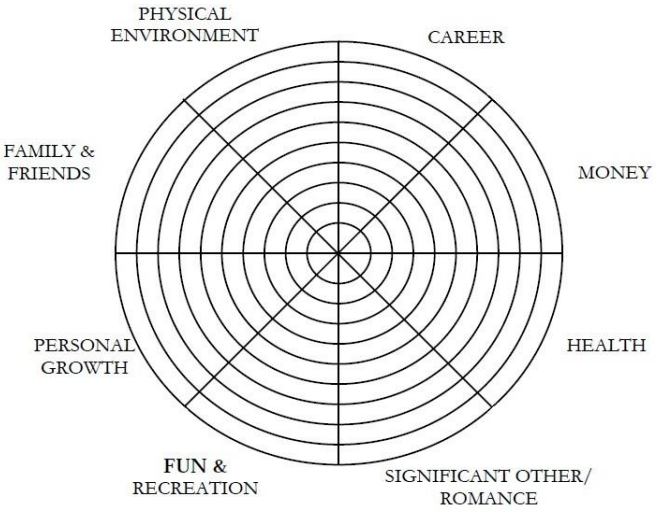
WHEEL OF BALANCE

Wellness is a balance of many factors.

Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

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FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Heart Disease / Heart Attack / Stent / Bypass / Stroke: _____
High Blood Pressure / High Cholesterol / Diabetes: _____
Breast / Ovarian Cancer: _____
Colon / Prostate Cancer: _____
Other Cancer: _____
Osteoporosis / Broken Bones: _____
Thyroid Problems: _____
Depression /Anxiety / Substance Abuse: _____
Bleeding Problems / Blood Clots: _____
Asthma / Hay fever: _____
Tuberculosis / Epilepsy: _____
Other: _____

_____

PAST MEDICAL HISTORY

Please circle those conditions that you've had in the past or have currently

Thyroid problems / Diabetes
Heart disease / Hypertension / Heart attack / Heart murmur
Asthma / Tuberculosis / Emphysema / COPD
Migraines
Seasonal Allergies
Arthritis
Seizures / Stroke
Gastro intestinal problems: jaundice / liver disease / gallbladder disease / pancreatitis / ulcer
Hemorrhoids / rectal bleeding / diverticulitis / hepatitis
Depression / Seasonal Depression /Anxiety / Considered suicide or attempted suicide
Treated for emotional problems
Head injury / MVA / other injuries / broken bones
Jaw or TMJ problems
Chronic sinus infections / frequent colds
Cancer
Blood Clots / varicose veins / trombophlebitis
Frequent UTI' s / Kidney stones
Reactions to immunizations
Experienced a major trauma
History of abuse
Treated for drug dependence
Endometriosis / Ovarian cysts
Difficulty conceiving
Heavy or irregular bleeding / Bleeding between cycles
Irregular cycles
Painful menses / PMS

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HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid Medication
Birth Control Pills	Hormone Replacement		

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

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

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GENERAL

Height: _____ Weight: _____ Weight one year ago: _____

Maximum Weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies: _____

Exercise: Y / N If so, what kind and how often: _____

Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? _____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

GENERAL

Do you sleep well?	Yes	No
Average 6-8 hours?	Yes	No
Awake rested?	Yes	No
Have a supportive relationship?	Yes	No
Use recreational drugs?	Yes	No
Use alcoholic beverages?	Yes	No
Use tobacco?	Yes	No
If in the past, how many years? _____		
How many packs per day? _____		
Do you enjoy your work?	Yes	No
Take vacations?	Yes	No
Spend time outside?	Yes	No
Eat three meals a day?	Yes	No
Do you go on diets often?	Yes	No
Do you eat out often?	Yes	No
Do you drink coffee?	Yes	No
Drink black/green tea?	Yes	No
Drink soda?	Yes	No
Do you eat refined sugar?	Yes	No

FEMALE REPRODUCTIVE

Age of first menses:_____		
Age of last menses (if menopausal):_____		
Length of cycle:_____days		
Duration of menses:_____days		
Date of last pap smear:_____		
Abnormal PAP?	Yes	No
Cervical dysplasia?	Yes	No
Are you sexually active?	Yes	No
Sexual orientation:_____		
Birth control? Type:_____		
Gonorrhea/ Herpes/ Chlamydia?	Yes	No
Genital warts or Syphilis?	Yes	No
Number of pregnancies:_____		
Number of live births:_____		
Number of miscarriages:_____		
Number of abortions:_____		
Do you do self breast exams?	Yes	No

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

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Rate each of the following symptoms based upon your typical health profile for the ***PAST 30 DAYS***.

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD	_____	Headaches or migraines	
	_____	Faintness / Dizziness	
	_____	Insomnia	TOTAL: _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	
		(does not include near or far-sightedness)	
	_____	Impaired vision	
	_____	Spots in vision	
	_____	Eye pain or strain	TOTAL: _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	TOTAL: _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	
	_____	Loss of smell	
	_____	Nose bleeds	TOTAL: _____
MOUTH / THROAT/ NECK	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	
	_____	Difficulty swallowing	
	_____	Lumps in neck / goiter	
	_____	Pain / stiff neck	TOTAL: _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin, eczema	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	
	_____	Lumps or bumps	
	_____	Change in skin color	
	_____	Boils, itching	TOTAL: _____
HEART	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	TOTAL: _____

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LUNGS / RESPIRATION	_____	Cough	
	_____	Sputum / Coughing up blood	
	_____	Chest congestion / Bronchitis, wheezing	
	_____	Shortness of breath	
	_____	Difficulty breathing / painful breathing	
	_____	Shortness of breath (while laying down)	TOTAL: _____
DIGESTIVE	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	
	_____	Bowel movements: change in frequency	
	_____	Black or blood in stools	TOTAL: _____
JOINTS / MUSCLES	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	
	_____	Muscle spasms / cramps	
	_____	Sciatica	TOTAL: _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	TOTAL: _____
ENERGY / ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	TOTAL: _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	TOTAL: _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	
	_____	Tension	TOTAL: _____

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ENDOCRINE	_____	Hypoglycemia	
	_____	Excessive thirst	
	_____	Heat or cold intolerance	
	_____	Excessive hunger	
	_____	Seasonal depression	
	_____	Difficulty exercising	TOTAL: _____
IMMUNE	_____	Chronically swollen glands	
	_____	Slow wound healing	
	_____	Chronic fatigue syndrome	
	_____	Chronic infections	
	_____	Night sweats	TOTAL: _____
NEUROLOGIC	_____	Seizures	
	_____	Muscle weakness	
	_____	Loss of memory	
	_____	Paralysis	
	_____	Numbness or tingling	
	_____	Easily stressed	
	_____	Loss of balance	TOTAL: _____
URINARY	_____	Increased frequency of urination	
	_____	Inability to hold urine	
	_____	Pain with urination	
	_____	Frequency at night	
	_____	Frequent UTI's	
	_____	Kidney stones	TOTAL: _____
BLOOD / CIRCULATION	_____	Anemia	
	_____	Easy bleeding or bruising	
	_____	Cold hands/feet	
	_____	Deep leg pain	
	_____	Varicose veins	TOTAL: _____
OTHER	_____	Frequent illness	
	_____	Genital itch or discharge	
	_____	Pain during intercourse	
	_____	Breast pain / tenderness	
	_____	Breast lumps	
	_____	Nipple discharge	
	_____	Menopausal symptoms	
	_____	PMS / Irregular or heavy bleedings	
	_____	Spotting between cycles	TOTAL: _____

GRAND TOTAL: _____