Northwest
INTEGRATIVE MEDICINE

Northwest Integrative Medicine New Patient Intake

Please indicate which provider you have an appointment with today:

_____ Stephanie Culver, ND _____ Maeghan Culver, ND _____ Teresa True, ND

Name: _____ **Date**: _____

Age: _____ **DOB**: _____

Identifying Gender: Male / Female / Other **Preferred Pronoun**: He/She/They

Telephone: (h) _____ (c) _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Email: _____

Emergency Contact: _____ **Relationship**: _____

Telephone: (h) _____ (c) _____

How did you hear about NWIM? _____

Note: Integrative preventative healthcare is enhanced dramatically when the practitioner has a complete picture of the patient physically, mentally, emotionally, and spiritually. We ask for your cooperation and patience as you complete this health history questionnaire. You may find that some of the information is difficult to recall. We only ask that you do your best. The more information you provide, the better we will be able to serve your needs.

Thank you for your cooperation and thoroughness. We look forward to working with you.

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HEALTH CONCERNS: Please list your most important physical, emotional, or mental health concerns. Indicate which is/are of the most immediate concern to you.

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH GOALS: Please list your health goals, ranking the most important first

1. _____
2. _____
3. _____
4. _____
5. _____

How do you rate your overall health? Excellent Good Fair Poor

What are your expectations for your first visit?

_____

HEALTH HISTORY

- When did you last receive medical care? _____
- Where (Clinic)? _____
- By whom (Practitioner)? _____

Please list the following:

Surgeries/ Date	Hospitalizations/Date

HEALTH STUDIES/LABS

- When was your last blood test? _____
- What is your blood type? _____
- Any other recent tests? _____

IMMUNIZATION HISTORY: Please indicate if you have received any of the following vaccines

Hep A	Y N	Tetanus (DtAP/TdAP)	Y N	Polio	Y N
Hep B	Y N	Flu (seasonal)	Y N	Shingles	Y N
HPV	Y N	MMR (Measles/Mumps/Rubella)	Y N	Rotovirus	Y N
Chicken pox	Y N	Pneumococcal	Y N	HiB	Y N
Smallpox	Y N	Meningococcal	Y N	TB	Y N

HISTORY- PERSONAL: Please list significant illness or diseases you have been diagnosed with in the past (ie. chicken pox, asthma) & the approximate date you were diagnosed.

1. _____
2. _____
3. _____
4. _____
5. _____

HISTORY- FAMILY: Please list ages and mark any major health problems. If deceased please list what they died from (ie. cancer, old age), and at what age.

	Living/ Deceased	Age	Cancer	Diabetes	High blood pressure	Thyroid disease	Auto-immune disease	Please Specify or Indicate Others
Immediate Family								
Mother	L D							
Father	L D							
Sisters	L D							
Brothers	L D							
Mother's Side								
Grandmother	L D							
Grandfather	L D							
Father's Side								
Grandmother	L D							
Grandfather	L D							

MEDICATIONS & ALLERGIES

PRESCRIBED & NATURAL MEDICINES Please list all prescribed drugs, vitamins, herbs, and others you are taking at present, with dosage.	ALLERGIES/INTOLERANCES Please list any food, medication, or environmental allergies and your reaction to them

SOCIAL HISTORY

Occupation: _____

Are you: ____Married ____Separated ____Divorced ____Single ____Widowed ____Partner

With whom do you live? ____Spouse ____Parents ____Relatives ____Friends ____Alone ____Other

Do you have the support of family and friends to make positive changes in your life?

_____

Have you traveled outside the US?

- Where & when? _____

Military status:

- Did you serve?

  When?_____

- Where? _____

Do you have a religious or spiritual practice? _____

In what areas of your life do you experience stress? ____Work ____Family ____Social ____Financial

ENVIRONMENTAL:
Check any of the following you routinely use at home or at work.
____Gas heat ____Oil heat ____Electric heat ____Wood stove ____Air conditioning ____Electric blanket

Water: ____Distilled ____Filtered ____Spring ____Well ____Tap/City

Are you exposed to environmental or chemical hazards at home or work? If yes, please specify.

_____

_____

DIET
Number of meals eaten per day: 1 2 3 More than 3

How is your appetite? ____Excellent/Love food! ____Good

____Eat food for sustenance ____ Go hours without eating

Do you follow any particular diet? If yes, please specify**:**

_____

List the primary foods in your diet:

_____

List the foods excluded from your diet**:**

_____

List any of the following (and relative amounts) eaten regularly by you:
Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods or food you suspect may be harmful to your health.

_____

List any of the foods you crave, **regardless of their nutritional value** (including sweets, salty, sour, bread, rich/fatty foods, etc.**)**

_____

Are you satisfied with your diet as it is now? _____ If not, why not? _____

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SYSTEMS REVIEW

Please circle: O - Occasionally Y - condition you **have now/past month** N - **never** had this problem P - condition you had in the **past**

GENERAL

Height: _____
Weight: _____
Weight 1yr ago: _____
Maximum weight: _____
When? _____
Last physical? _____
Average number of hours of sleep: _____

Fatigue	O	Y	N	P
Trouble falling asleep	O	Y	N	P
Trouble staying asleep	O	Y	N	P
Night sweats	O	Y	N	P

SKIN

Rashes	O	Y	N	P
Itching	O	Y	N	P
Color change	O	Y	N	P
Lumps	O	Y	N	P
Varicose veins	O	Y	N	P

HEAD

Headaches	O	Y	N	P
Head injury	O	Y	N	P
Dizziness/vertigo	O	Y	N	P
Hair loss	O	Y	N	P

EYES

Impaired vision	O	Y	N	P
Eye pain	O	Y	N	P
Tearing/dryness	O	Y	N	P
Double vision	O	Y	N	P
Cataracts	O	Y	N	P
Bulging eyes	O	Y	N	P

EARS

Impaired hearing	O	Y	N	P
Ringing	O	Y	N	P
Earache	O	Y	N	P

NOSE/SINUS

Frequent colds	O	Y	N	P
Nose bleeds	O	Y	N	P
Stuffiness	O	Y	N	P
Sinus problems	O	Y	N	P

MOUTH &THROAT

Frequent sore throat	O	Y	N	P
Gum problems	O	Y	N	P
Hoarseness	O	Y	N	P
Difficulty swallowing	O	Y	N	P

NECK

Lumps	O	Y	N	P
Swollen glands	O	Y	N	P
Goiter	O	Y	N	P

PSYCH

Depression	O	Y	N	P
Anxiety	O	Y	N	P
Hallucinations	O	Y	N	P
Mood Swings	O	Y	N	P
Memory Loss	O	Y	N	P

(CIS) Men

Currently sexually active? Yes No
Have you been in the past? Yes No
Type of contraception used? _____
Have you had a prostate exam? Yes No
If so, when? _____
Sexual Desire:
0 1 2 3 4 5 6 7 8 9 10

MALE GENITAL

Erectile dysfunction	O	Y	N	P
STDs	O	Y	N	P
Penile infections/inflammation	O	Y	N	P
Split urine stream	O	Y	N	P
Abnormal discharge	O	Y	N	P
Redness	O	Y	N	P
Prostatitis	O	Y	N	P
Blood in semen	O	Y	N	P
Painful ejaculation	O	Y	N	P
Lump in testicle	O	Y	N	P
Painful testicles	O	Y	N	P

CARDIOVASCULAR

Heart disease	O	Y	N	P
Murmurs	O	Y	N	P
Chest pain	O	Y	N	P
High blood pressure	O	Y	N	P
Swelling in ankles	O	Y	N	P
Palpitations	O	Y	N	P

RESPIRATORY

Cough	O	Y	N	P
Wheezing	O	Y	N	P
Short of breath at night	O	Y	N	P
Short of breath lying down	O	Y	N	P
Pain with breathing	O	Y	N	P
Trouble breathing	O	Y	N	P
Emphysema	O	Y	N	P
Asthma	O	Y	N	P
Bronchitis	O	Y	N	P
Pneumonia	O	Y	N	P

URINARY

Pain with urination	O	Y	N	P
Increased frequency	O	Y	N	P
Frequency at night	O	Y	N	P
Unable to hold urine (urgency)	O	Y	N	P
Frequent infections	O	Y	N	P
Kidney stones	O	Y	N	P

MUSCULOSKELTAL

Joint pain	O	Y	N	P
Arthritis	O	Y	N	P
Muscle pain	O	Y	N	P

NEURO

Muscle weakness	O	Y	N	P
Fainting	O	Y	N	P
Seizures	O	Y	N	P
Numbness/Tingling	O	Y	N	P

BLOOD

Easy bruising	O	Y	N	P
Clotting disorders	O	Y	N	P

(CIS) Women

Currently sexually active? Yes No
Have you been in the past? Yes No
Sexual Desire:
0 1 2 3 4 5 6 7 8 9 10
Type of contraception used? _____

Do you have a period? Yes No

- Age of first period _____
- Period is/was every ___ days, _____
  lasting ___ days _____
- Is/Was period regular? Yes No
- Quality of blood (dark, clots): _____
- Flow on first day (#pads or tampons/day) (heavy, light): _____
- Date of last period: _____

Date when menopause began: _____

Date of last PAP: _____

Ever had an abnormal PAP? Yes No
If yes, please explain: _____
Number of: ____ Pregnancies ____ Miscarriages
____ Births ____ Abortions

BREASTS

Breast pain	O	Y	N	P
Lumps	O	Y	N	P
Infection	O	Y	N	P
Nipple discharge	O	Y	N	P

FEMALE GENITAL

Problems with infertility?	O	Y	N	P
Abnormal discharge	O	Y	N	P
Redness	O	Y	N	P
Itching	O	Y	N	P
Sense of pelvic fullness	O	Y	N	P

ENDOCRINE

Hypothyroid	O	Y	N	P
Hyperthyroid	O	Y	N	P
Cold/Heat Intolerance	O	Y	N	P
Low blood sugar	O	Y	N	P
Diabetes	O	Y	N	P

GASTROINTESTINAL

Nausea	O	Y	N	P
Vomiting	O	Y	N	P
Diarrhea	O	Y	N	P
Constipation	O	Y	N	P
Gas/Belching	O	Y	N	P
Heart burn	O	Y	N	P
Indigestion	O	Y	N	P
Blood in vomit	O	Y	N	P
Blood in stool	O	Y	N	P
Abdominal cramping	O	Y	N	P
Hemorrhoids	O	Y	N	P
Hernia	O	Y	N	P
Gallbladder problems	O	Y	N	P
Liver problems	O	Y	N	P