Everhope Clinic PLLC
Naturopathic Medicine

Please complete this form as thoroughly as possible in order to aid your physician in her diagnosis and treatment. This information will become part of your confidential medical record and will not be shared unless you expressly authorize its release.

PATIENT PROFILE

Today's Date: _____ SSN: _____-_____-_____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: ____ Sex: ____ F ____ M ____ Other: _____

Address: _____ City: _____ State: ____ Zip: _____

Email: _____ May we add you to our email list? ____ Yes ____ No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave confidential voicemail messages for you at any of the above numbers? ____ No ____ Yes
If yes, please indicate which ones: ____ Home ____ Work ____ Cell

Occupation: _____ Employer: _____

Domestic Status: ____ Single ____ Partnered ____ Married ____ Separated ____ Divorced ____ Widowed

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear of us?

____ Physician: Dr. _____ ____ Friend ____ Flyer ____ Internet Search

____ MANP "Find an ND" ____ ILADs ____ Other: _____

Very briefly, what brings you in to this first visit? _____

CURRENT HEALTH

Current Primary Care Physician? _____ Phone: _____

Clinic Name: _____ Date of Last Visit: _____

Address, City, State, Zip: _____

Height: _____ Current Wt: _____ lbs

How do you describe your health in general? ____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

Everhope Clinic PLLC
Naturopathic Medicine

PAST MEDICAL HISTORY

Major Injuries

Please include auto accidents, sports injuries, and other injuries.

	Injury	Date	Outcome
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Hospitalizations

	Reason	Date	Outcome
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Surgeries

	Type	Reason	Date	Outcome
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Serious Illnesses

	Type	Date	Outcome
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Date of last physical/annual exam: _____

Date of last blood tests: _____

HEALTH RISKS

Tobacco

Do you currently or did you ever use tobacco products? ____ No ____ Yes

Alcohol

Do you consume alcoholic beverages? _____ No ____ Yes

If yes, please indicate type and how much:

Beer	____ 12 oz can/wk
Wine	____ 5 oz glass/wk
Hard Alcohol	____ 1.5 oz/wk
Other	____/wk, specify: _____

Caffeine

Do you consume caffeinated beverages? ____ No ____ Yes

If yes, please indicate type and how much:

Coffee	____ oz/day
Black Tea	____ oz/day
Soda	____ oz/day

Name	Measurement
Demi	3 US fl oz (89 mL)
Short	8 US fl oz (240 mL)
Tall	12 US fl oz (350 mL)
Grande	16 US fl oz (470 mL)
Venti	20 US fl oz (590 mL), 26 US fl oz (770 mL)
Trenta	31 US fl oz (920 mL)

Recreational Drugs

Do you use recreational drugs? ____ No ____ Yes

If yes, please indicate type and how often:

Marijuana	____/wk	Amphetamine	____/wk
Cocaine	____/wk	Crack	____/wk
Injectable	____/wk, specify: _____		
Other	____/wk, specify: _____		

Everhope Clinic PLLC
Naturopathic Medicine

MEDICATIONS AND ALLERGIES

Medication	Dosage and Frequency (mcg, mg, ml, units, drops)	Route (Oral, sublingual, injection, IV, rectally, vaginally)	Prescribed by (Doctor's name or Self)	Purpose and Date Started
Prescription Medications				
Supplements, Vitamins, Herbals				
Homeopathics				

Have you experienced any intolerances or allergic reactions to any medications or supplements or had to lower the dose due to being too sensitive to a normal dose? ____ No ____ Yes

If yes, please list the medication or supplement and describe the reactions you experienced.

Medication/Supplement Reaction

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

Everhope Clinic PLLC
Naturopathic Medicine

REVIEW OF SYSTEMS

Indicate with a C any conditions you currently have or a P for conditions you've had in the past that have since resolved.

	Constitutional		Mental		Neurological		Integumentary
	Fatigue / Tiredness		Anxiety		Dizziness		Skin Rash / Itching
	Fever		Depression		Fainting		Skin Infections
	Night Sweats		Brain Fog		Recurrent Headaches		Growths
	Poor Sleep		Forgetfulness		Migraines		Mole Change
			Mood Swings		Numbness		Nail Problems
			Anger Outbursts		Weakness		Recent Hair Loss
			Other:		Tingling Sensation		

	Endocrine		Immune System		Ear and Eye		Respiratory
	Thyroid Disorder		Cancer		Hearing Loss		Freq. Sore Throats
	Diabetes		Autoimmune		Ringing in Ear(s)		Freq. Sinus Infections
	Other:_____		Allergies		Earache		Asthma
	Other:_____		Hay Fever		Dizziness (faint)		Difficulty Breathing
			Enlarged Lymph Node		Vertigo (room spins)		Shortness of Breath
			Frequent Colds / Flu		Recent Vision Change		Chronic Bronchitis
					Eye Pain		Chronic Cough
					Dry Eyes		Tuberculosis
					Double Vision		Pneumonia (bacterial)
							Pneumonia (viral)
							Chest Pain

	Gastrointestinal		Cardiology / Hematology		Genitourinary		Gynecological
	Stomach Ulcers		Chest Pain		Kidney Failure		PMS
	Acid Reflux		Heart Disease		Kidney Infection		Menstrual Cramps
	Gas and Bloating		Heart Failure		Kidney Stones		Heavy Menstrual Flow
	Constipation		Stroke		Bladder Infection		Irregular Cycles
	Diarrhea (infectious)		Irregular Heartbeat		STD - Chlamydia		Menopause
	Diarrhea (bloody)		Hemorrhoids-external		STD - HIV		Hot Flashes
	Blood in Stools		Hemorrhoids-internal		STD - HPV		Vaginal Discharge
	Persistent Nausea		Frequent Nose Bleeds		STD - Syphilis		Breast Discharge
	Recurrent Vomiting		Varicose Veins		STD - Other		Dense Breasts
	Liver Disease		Poor Circulation		Prostate Enlargement		Other Breast Issues
	Hepatitis		Anemia		Erectile Dysfunction		
	Abdominal Pain		Blood Diseases		Loss of Libido		
			Easy Bruising				

	Musculoskeletal		Metabolic		Other (write-in)
	Arthritis		Loss of Appetite		
	Back Pain		Weight Gain		
	Joint Pain		Weight Loss		
	Stiffness		Weight redistribution		
	Bursitis				
	Fibromyalgia				

Everhope Clinic PLLC
Naturopathic Medicine

FAMILY HEALTH HISTORY

Please indicate which of the following health problems your family (mother, father, siblings, children, or grandparents) has experienced. If it is a current condition, enter the letter C in the column next to the condition. Use the letter P to indicate a past problem that has resolved. Where there is an underline in the Condition column, please indicate type of condition. For the "other" columns, after the C or P, write in the family relationship ("brother", "sister", "grandmother", etc.) and their current age or age at death.

Condition **Current Age/Age at Death**	**Father** _____	**Mother** _____	**Other – Who and Age**	**Other – Who and Age**	**Other – Who and Age**
Alzheimer's					
Allergies/Hay Fever					
Asthma					
Anemia					
Arthritis _____					
Autoimmune _____					
Cancer _____					
Cancer _____					
Cancer _____					
Diabetes					
Digestive Problems					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Liver Disease					
Lung Disease					
Lyme Disease					
Mental Illness					
Migraine					
Mood Disorder _____					
Obesity					
Osteoporosis					
Stroke					
Substance Abuse					
Thyroid Disorder					
Ulcer					
Other _____					
Other _____					