Eastside Natural Health Clinic

Confidential Health Assessment

Please complete this questionnaire as completely, and honestly as possible to assist us in obtaining an accurate picture of your physical, mental and emotional health. Thank you.

Name: _____ Age:____ Today's Date:_____
Address:_____City:_____ Zip:_____
Home phone:_____ Business phone:_____ Mobile: _____ Date of birth: _____
E-Mail: _____ Occupation:_____ Employer:_____ How long? _____
Living Situation: Alone ____ Spouse ____ Partner____ Friend(s) ____ Parents____ #of children ____
In case of emergency notify: _____ Phone number: _____
Insurance coverage: _____
Whom may we thank for referring you? _____

Intention For This Appointment.

_____
_____
_____
___

Are you being treated elsewhere?_____ If yes, please list the names/types of other practitioners:
_____

Medical History:

Have you ever consulted a Naturopathic Doctor before?_____ If so, please explain the results: _____
_____

Hospitalizations and surgeries. Please list the date, outcome and any additional comments.
_____
_____

List any major illnesses experienced at any time in your life:
_____
_____

Known allergies (please include drugs, foods, and environmental):
_____
_____

Current medications. Please include herbs, vitamins, and other supplements and if they were prescribed by someone:
_____
_____
_____

Past medical conditions. Please circle any conditions you have been diagnosed with in the *past*:

Arthritis	Respiratory Illness	Allergies/Hayfever	Parasites
Asthma	Gastrointestinal problems	Eating disorder	Thyroid disorder
Bleeding problems	Clotting defects	Heart problems	Stroke
Cancer	Diabetes	Hepatitis	Psychological problems
Chronic fatigue	Epilepsy	High blood pressure	
Other_____	Eczema	Sinus problems	

Review of Systems: Please circle any of the following symptoms that are of *present* significance:

Fatigue
Fever or chills
Perspiration
Weight change
Hot flashes
Swelling
Night sweats
Rashes
Inflammation
Eruptions
Easy bruising
Slow healing
Unusual growths
Change in hair or nails
Headache
Dizziness
Dry eyes
Visual problems
Sinus trouble
Fainting
Bleeding gums
Lump in the throat
Dental problems
Hearing problems
Ringing in ears

Frequent colds
Sore neck
Swollen glands
Wheezing
Chest pain/tightness
Shortness of breath
Palpitations
Chronic cough
Coughing blood
Urinary frequency
Urinary urgency
Pain with urination
Blood in urine
Inability to hold urine
Recurrent bladder infections
Kidney stones
Sexual dysfunction
Joint pain
Stiffness
Muscle pain
Weakness
Depression
Mood swings
Anxiety
Tension

Paralysis
Numbness
Tingling
Memory loss
Heartburn
Trouble swallowing
Excess burping
Gas
Bloating
Intestinal cramps/pain
Nausea
Vomiting
Change in appetite
Change in thirst
Hemorrhoids
Laxative use
Stools difficult to pass
Stools light colored
Black/tarry stools
Blood in stool
Loose stools
I move my bowels ___
times per day/week.

Do you have any other health concerns that you would like to share that have not yet been addressed?

_____

Family History: Please indicate which, if any, family members have had any of the following diseases:

____Alcoholism/Addictions
____Hypertension
____Heart Disease
____Cancer
____Diabetes
____Osteoporosis
____Arthritis
____Auto-immune disorders
____Epilepsy
____Hepatitis
____Kidney Disease
____Stroke
____Asthma
____Allergies
____Psoriasis
____Mental Illness
____Other

Lifestyle Assessment:

How do you rate your general health? __ Excellent __ Good __ Fair __ Poor __
Do you exercise regularly? _____ Type of exercise?_____ How often? _____ How long?_____
How do you rate your sleep? ❑Excellent ❑Good ❑Fair ❑Poor ❑Getting better ❑Getting worse
How many hours do you sleep? _____ What time do you go to bed?_____ What time do you wake up? _____
Do you wake feeling rested? _____ Do you take anything to help you sleep? _____
Do you participate in any of the following:
____Meditation/Visualization ____Prayer/Spiritual practice ____Yoga ____Tai Chi
____Psychotherapy/counseling ____Bodywork (chiropractic, massage, rolfing, etc.)

Food Choices:

The type of diet I usually follow is classified as _____
Any dietary preferences or restrictions? _____
How much water do you drink in one day? _____
My Blood-Type is: _____

Please grade the dietary selections as they currently apply to you using the following scale:

D - Consume daily
W - Consume weekly
M - Consume monthly
N - Never consume

____ Alcohol
____ Tobacco
____ Antacids
____ Soda-diet/reg.
____ Coffee/Tea
____ Herbal teas
____ Filtered water

____ Diet food/plans
____ Fasting
____ Artificial sweetner
____ Refined sugar
____ White flour
____ Crisco
____ Margarine
____ Fast foods
____ Frozen foods
____ Canned foods
____ Legumes, beans

____ Tofu, tempeh
____ Beef
____ Pork
____ Poultry
____ Luncheon meats
____ Fish-fresh/frozen
____ Milk -cow, soy
____ Yogurt
____ Cheese
____ Butter
____ Eggs

____ Nuts & seeds
____ Cold-pressed oils
____ Flax/Fish oil
____ Fresh juices
____ Fresh fruit
____ Fresh vegetables
____ Organic foods
____ Pasta
____ Whole grains (brown rice, millet, oats, quinoa, etc.)

Chemical Exposure: Please check all that apply to you.

____Was your mother taking any drugs, medications, alcohol, or tobacco during her pregnancy with you?
____Are you exposed to second hand smoke?
____Do you use, or have you ever used recreational drugs?
____Have you ever taken steroid-based medication?
____Do you take NSAIDS or aspirin on a regular basis?
____Do you have a history of recurrent antibiotic use?
____Are you exposed to chemicals/fumes at work?
____Are you sensitive to strong chemicals or strong odors?
____Do you have any specialized filtration units in your home?
_____ Do you have silver dental fillings? #_____

What are the most significant measures you have taken to improve your state of health and wellness in the past year?
_____
__
_____
__

What are the three most significant stressors or stressful events in your life, from the most recent to the most distant. Do they continue to impact your life today?_____
_____
__

What brings you joy in life?
_____

Insurance Information:

Name on the account _____
Date of Birth of the above listed person _____
Employer of the above listed person _____
Relationship to patient _____
Insurance company_____

Contract number_____
Group number _____
Phone number _____
Address of Insurance _____
_____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above stated company and assign to Dr. Uli Knorr all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible party signature, or authorized party Date

Thank you for filling out this intake form!

Women, please see next page.

Gynecological History:

Date last period began:_____ Date prior period began: _____ Age of first period: _____
Date of last pelvic exam: _____ Date of last PAP smear: _____ Were the results normal? _____
If no, please explain: _____
Have you ever had an abnormal Pap? ____ When? _____ Results? _____ Treatment? _____
Do you do self-breast exams? _____ Have you ever had a mammogram? _____ Date: _____
Were the results normal? _____ If no, please explain: _____
Have you passed the menopause?____ When? _____ Do you take hormones (natural or synthetic)? _____
What symptoms do you experience which you believe to be related to menopausal changes? _____
_____
_____
____
Have you had a hysterectomy? _____ When? _____ Was it complete or partial? _____
For what reason? _____

Normally (not on pills) the number of days from the start of one period to the start of the next _____
Number of days of flow ____ Amount of bleeding: ❑ Heavy ❑ Moderate ❑ Light. Do you pass clots?_____
Do you experience cramping? _____ If yes, at what point in your cycle? _____
Any changes in your normal patterns?_____ Do you know when you ovulate? ____ How do you know? _____
Premenstrual symptoms?_____ If yes, at what point in your cycle? _____
Any bleeding, or spotting, between periods? _____ When? _____
Any unusual pelvic pain, pressure or fullness? _____ When? _____ Describe: _____
Any unusual vaginal discharge, itching, or odor?_____ Describe: _____
How long? _____ Treatment? _____

Do you have any sexual concerns to discuss today? _____
Any past history of sexually transmitted diseases?_____
Are you presently sexually active? _____ Do you have intercourse? _____ Do you practice safe sex? _____
Are you trying to get pregnant? _____ How long? _____
Current form of birth control: _____ Are you satisfied with this method? ____
What problems do you experience with this method? _____
What methods have you used in the past? _____ Any problems with those methods? _____
Have you ever been pregnant? _____ Number of pregnancies (include miscarriages and abortions) _____
Number of children _____ Problems with pregnancies &/or childbirth? _____