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	____ Diet food/plans	____ Tofu, tempeh	____ Nuts & seeds
W - Consume weekly	____ Fasting	____ Beef	____ Cold-pressed oils
M - Consume monthly	____ Artificial sweetner	____ Pork	____ Flax/Fish oil
N - Never consume	____ Refined sugar	____ Poultry	____ Fresh juices
____ Alcohol	____ White flour	____ Luncheon meats	____ Fresh fruit
____ Tobacco	____ Crisco	____ Fish-fresh/frozen	____ Fresh vegetables
____ Antacids	____ Margarine	____ Milk -cow, soy	____ Organic foods
____ Soda-diet/reg.	____ Fast foods	____ Yogurt	____ Pasta
____ Coffee/Tea	____ Frozen foods	____ Cheese	____ Whole grains
____ Herbal teas	____ Canned foods	____ Butter	(brown rice, millet,
____ Filtered water	____ Legumes, beans	____ Eggs	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? _______________________________