Heart Spring Health

819 SE Morrison St, Suite 115
Portland, OR 97214

Phone: 503-956-9396
Fax: 866-883-0582

Date: _____ Full Legal Name: _____ Birth Date: _____/_____/_____

Current Condition/Complaints (Please fill in as completely as possible)

What is your **primary complaint/problem**?_____

Other symptoms_____

How did your symptoms first begin?_____

When did your symptoms first begin (give date if possible)?_____

Have you had **symptoms like this before**? ☐No ☐Yes (describe) _____

Are your symptoms **getting worse**? ☐No ☐Yes Are they worse **at certain times** of the day or night? _____

What makes your symptoms **worse**? (list) _____

What makes your symptoms **better?** (list) _____

List *all* doctors/therapists/specialists **seen for this problem** & treatment received:

_____

Have you had: ☐ X-ray ☐ MRI or CAT Scan ☐ EMG ☐ Bone Scan ☐ Blood Work

How do your symptoms **interfere with your normal daily routine**? _____

List all current over-the-counter and prescription **Medication/Vitamins/Supplements/Herbs/Birth Control** (include reason):

_____

_____

List any **allergies or food sensitivities**:_____

Have you ever had any of the following therapies before? ☐ Chiropractic ☐Acupuncture ☐Massage ☐Naturopathic
Are you currently under the care of a physician? ☐ NO ☐YES
Date of last exam? _____ Physician's Name: _____
If female, is there **a possibility that you are pregnant?** ☐ NO ☐ YES

Check the box for the following **symptoms you are experiencing NOW or have experienced in the PAST**:
[N] = NOW [P] = PAST

[N] [P]	[N] [P]	[N] [P]
☐ ☐ Headaches	☐ ☐ Arm/hand numbness/tingling	☐ ☐ Chills/fever
☐ ☐ Visual or hearing pain or loss	☐ ☐ Arm/hand fatigue/weakness	☐ ☐ Dizziness or light-headedness
☐ ☐ Sinus pain	☐ ☐ Joint pain or swelling	☐ ☐ Memory loss or disturbances
☐ ☐ Jaw pain, clicking, or locking	☐ ☐ Leg/foot numbness/tingling	☐ ☐ Anxiety or depression
☐ ☐ Neck pain or stiffness	☐ ☐ Leg/foot fatigue/weakness	☐ ☐ Fatigue or loss of energy
☐ ☐ Pain or difficulty swallowing	☐ ☐ Nausea or vomiting	☐ ☐ Fainting or convulsions
☐ ☐ Low back pain	☐ ☐ Diarrhea or constipation	☐ ☐ Trouble with balance
☐ ☐ Chest pain	☐ ☐ Blood in urine or stool	☐ ☐ Insomnia or Excessive Sleepiness
☐ ☐ Pain with/trouble breathing	☐ ☐ Difficulty or pain w/urination	☐ ☐ Skin disorders (rashes, etc)
☐ ☐ Abdominal Pain	☐ ☐ Difficulty with sexual function	☐ ☐ Weight gain/loss
☐ ☐ Indigestion	☐ ☐ PMS/Menstrual Disorders	☐ ☐ Symptoms of menopause
☐ ☐ Frequent Colds	☐ ☐ Infertility	☐ ☐ Excessive Thirst

Please turn over to complete form

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Medical History (Please fill in as completely as possible)

List any **Surgeries or Hospitalizations** (include dates & reasons): _____

List any **Significant Trauma** (Auto accidents, falls, etc. include dates):_____

List any **Previous or Childhood Illnesses** (include dates): _____

Medical Conditions **YOU** have or that run in your **FAMILY:** (Please check if any of the following that apply):

[Y] = YOU [F] = FAMILY

[Y][F]	[Y][F]	[Y][F]	[Y][F]
☐ ☐ High/Low Blood Pressure	☐ ☐ Thyroid Disorder	☐ ☐ Stomach Ulcer	☐ ☐ Cancer Type:_____
☐ ☐ Cholesterol Problems	☐ ☐ Diabetes Type: _____	☐ ☐ Irritable Bowel	☐ ☐ HIV/AIDS
☐ ☐ Heart Disease	☐ ☐ Hepatitis Type: _____	☐ ☐ Acid Reflux	☐ ☐ Multiple Sclerosis
☐ ☐ Bleeding/Clotting Disorder	☐ ☐ Alcoholism	☐ ☐ Arthritis	☐ ☐ Anxiety
☐ ☐ Anemia	☐ ☐ Asthma	☐ ☐ Osteoporosis	☐ ☐ Depression
☐ ☐ Stroke	☐ ☐ Allergies	☐ ☐ Epilepsy	☐ ☐ Other: _____

Diet and Personal Habits: (Check all that apply)

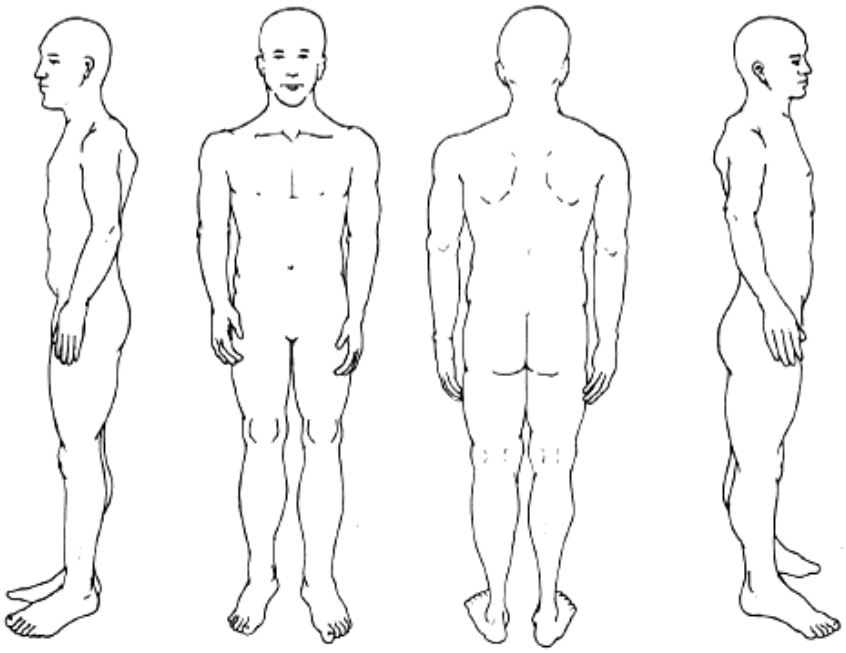
Tobacco	☐ no	☐ yes, _____	(#) packs per day	☐ Former tobacco use
Alcohol	☐ no	☐ yes, _____	(#) drinks per week	
Recreational drugs	☐ no	☐ yes, _____	(#) times per week	
Exercise	☐ Regularly	☐ Occasionally	☐ Not at all	
Diet	☐ Vegetarian	☐ Vegan	☐ Eat a lot of Red Meat	☐ Eat a lot of Sweets
	☐ Paleo	☐ Eat a lot of Dairy	☐ Eat a lot of Fried Foods	☐ Drink a lot of Coffee or Soda
Weight for height	☐ Normal	☐ Underweight	☐ Overweight	
Work/Study	☐ Full-time	☐ Part-time	☐ At night	☐ Unemployed

Any **Additional Information** about yourself: _____

_____

Use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom.

A= Ache or Sore
B = Burning
P = Pain or Tenderness
S = Joint or Muscle Stiffness
N= Numbness or Tingling
O= Other (Stabbing, pins/needles, etc)



_____
Patient Signature

_____
Date