Heart Spring Health

819 SE Morrison St. #115 Portland, OR 97214 503-956-9396

Patient Information:

Name:_____Date: _____

Address: _____Apartment:_____

City: _____ State: _____ Zip Code: _____

Phone- Day: (__) _____ Evening:(__) _____Cell:(__)_____Preferred:_____

Message OK: Y N E-mail address: _____

Age: _____ Date of Birth: _____ Gender: female ___ male____

Married_____ Partnered_____ Separated_____ Divorced_____ Widowed_____ Single_____

Housing: Spouse/Partner_____ Parents____ Children____ Friend/Roommate____ Alone ____

Occupation: _____ Hours per week: _____Retired: _____

Employer: _____ S.S.#: _____

(Work address): _____

Emergency contact: _____

Relationship: _____ Phone: _____

Address: _____

_____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

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What expectations do you have from this visit?

- What long-term expectations do you have?

- What expectations do you have of me as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)
0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health and in adhering to the therapeutic protocols, which we will be sharing with you?

6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

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Are you currently receiving healthcare? Y N

If yes, where and from whom:_____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Habits/Environment:

Do you enjoy your work? Y N
Do you take vacations? Y N
Do you watch television? Y N
How many hours? _____
What is restful and restorative for you?
_____
What gives you purpose and meaning?
_____
Do you have a religious or spiritual practice? Y N
If yes, what?_____
Do you exercise? Y N
If yes, what kind?_____
How many days/wk? _____
For how long? _____
Fresh air and exposure to sun? How often?
_____

Sleep well? Y N
Average 8 hrs. sleep? Y N
Awaken rested? Y N
What is your **best** time of day? _____
Worst time of day? _____
Do you eat 3 meals a day? Y N
Favorite foods?_____
Do you eat protein with every meal? Y N
Do you go on diets? Y N P
Do you eat a special diet? Y N P
Type of diet you follow?_____
Are there foods that you know do not agree with you? Y N
If so, which foods?
_____
Do you add salt? Y N P

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Do you eat sugar? Y N P
Drink coffee, black/green tea, energy drinks or soda? (please circle all that apply) Y N P
Do you eat chocolate? Y N P
Do you eat out often? Y N
Water intake/day? _____
Exposure to environmental toxins? Y N P
Do you use tobacco? Y N P
Think about quitting? Y N

Date of last tobacco:_____
Smoked for how many years? _____
How many packs per day? _____

Use alcoholic beverages? Y N P
Treated for alcoholism? Y N P
Use recreational drugs? Y N P
Been treated for drug dependence? Y N P

Family History

Do you have a family history of any of the following? Please circle and follow with **brief** description of **type** of disease (e.g. breast cancer, depression etc.) and who in your family was affected.

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Mental Illness	Autoimmune disease
Asthma	Anemia		

Any other relevant family history? _____

_____

Childhood Illnesses

Please circle if you had any of these as a child or an adult (please indicate if you got them as an adult):

Scarlet fever	Diphtheria	Rheumatic fever
Mumps	Measles	German measles

Are your immunizations up to date? _____
Please list any you believe you need: _____

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, Dental work, X-Rays, CAT Scans, ultrasounds, EEG, EKG's, Mammogram, Bone scan, DEXA, Colononoscopy, lung function tests have you had?

_____year: _____ _____ year: _____
_____year: _____ _____ year: _____
_____year: _____ _____ year: _____

Heart Spring Health

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Major events or health conditions that occurred during your lifespan:

0-5 years_____

5-10 years _____

10-15 years_____

15-20 years_____

20-30 years_____

30-40 years_____

40-50 years_____

50-60 years_____

60+ years_____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

Medications:

Circle any you have taken before

Laxatives	Appetite suppressants	Sleeping pills	Allergy meds
Pain reliever	Antibiotics	Stimulants	Hormone replacement
Antacids	Tranquilizers	Antidepressants	Asthma meds
Cortisone	Thyroid medication	Diabetic meds	

Others:

_____

_____

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Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are ***currently*** taking? **Please list doses and frequency**

1)_____ 4) _____

2)_____ 5) _____

3)_____ 6) _____

7)_____ 8) _____

9)_____ 10) _____

General

Height: _____Weight:_____ lbs. Birth weight_____ (if known) Fever or chills? Y N

Recent change in weight? Y N if so, how much? _____ Weight 1 year ago: _____lbs

Maximum Weight: _____ When: _____

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P
Lightheaded	Y N P		

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Hearing loss?	Y N P	Ringing?	Y N P
Earache or pain?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness or discharge?	Y N P	Hayfever?	Y N P
Sinus pain or problems?	Y N P	Loss of smell?	Y N P
Itching?	Y N P		

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

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Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Difficulty breathing w/ exercise?	Y N P
Shortness of breath at night?	Y N P	" " " lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Chest pain?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Palpitations/Fluttering?	Y N P	Fainting?	Y N P
Rheumatic Fever?	Y N P	Phlebitis?	Y N P
Swelling in ankles?	Y N P	Shortness of breath w/ exertion?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Excessive bloating?	Y N P
Heartburn?	Y N P	Ulcer?	Y N P
Reflux?	Y N P	Jaundice (yellow skin)?	Y N P
Change in appetite?	Y N P	Gall Bladder disease?	Y N P
Nausea/vomiting	Y N P	Liver Disease?	Y N P
Coughing up blood?	Y N P	Bowel Movements:	
Hemorrhoids?	Y N P	How often? _____times a day/week	
Constipation?	Y N P	Straining while passing stool?	Y N P
Diarrhea?	Y N P	Undigested food in stool?	Y N P
Abdominal pain or cramps?	Y N P	Black stools?	Y N P
Belching or passing gas?	Y N P	Loose or narrow stools?	Y N P

Urinary

Urgency with urination?	Y N P	Pain on urination?	Y N P
Increased frequency?	Y N P	Frequency at night?	Y N P
Cloudy urine or blood in urine?	Y N P	Changes in force of stream?	Y N P
Hesitancy or dribbling with urination?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

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Female Reproduction / Breasts

Age of first menses? _____
Age of last menses? (if menopausal) _____
Length of cycle? _____ days
Duration of menses? _____ days
Cycles regular? Y N P
Date of last annual exam/ PAP _____
Bleeding between cycles? Y N P
Clotting? Y N P
Painful menses? Y N P
Heavy or excessive flow? Y N P
Explain: (pads/tampons per day) _____
_____
PMS? Y N P
If yes, what are your symptoms?
_____
Vaginal discharge? Y N P
Itching? Y N P
Sores or lumps? Y N P
Are you sexually active? Y N
Sexual orientation: _____
Birth control? Y N P
What type? _____

Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____
Difficulty conceiving? Y N P
Pain during intercourse? Y N P
Ovarian cysts? Y N P
Endometriosis? Y N P
Abnormal PAP? Y N P
Cervical Dysplasia? Y N P
Menopausal symptoms? Y N P
Sexual difficulties? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Condyloma? Y N P
Herpes? Y N P
Syphilis? Y N P
Breasts:
Do you do breast self exams? Y N P
Breast pain/tenderness? Y N P
Breast lumps? Y N P
Nipple discharge? Y N P

Male Reproduction

Hernias? Y N P
Testicular pain? Y N P
Prostate disease? Y N P
Venereal disease? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Impotence? Y N P
Premature ejaculation? Y N P

Discharge or sores? Y N P
Testicular masses? Y N P
Are you sexually active? Y N
Sexual orientation: _____
Birth control? Type? _____
Syphilis? Y N P
Condyloma? Y N P
Herpes? Y N P

Musculoskeletal

Joint pain or stiffness? Y N P
Broken bones? Y N P

Arthritis? Y N P
Weakness? Y N P

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Muscle spasms or cramps?	Y N P	Gout?	Y N P
Blood / Peripheral Vascular			
Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P
Blood clots?	Y N P	Past transfusions?	Y N P
Immune			
Chronic infections?	Y N P	Autoimmune condition?	Y N P
Reactions to immunizations?	Y N P	Chronic Fatigue?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P
Endocrine			
Hypo or hyper thyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive sweating?	Y N P
Fatigue?	Y N P	Excessive thirst or hunger?	Y N P
Neurologic			
Fainting?	Y N P	Seizures?	Y N P
Paralysis?	Y N P	Muscle weakness?	Y N P
Numbness or tingling?	Y N P	Tremors or twitches?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P
Skin			
Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils, or sores?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps, bumps, growths?	Y N P	Night Sweats?	Y N P
Mental / Emotional			
Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P
Have a history of abuse?	Y N	Any major traumas?	Y N P