

## ADULT PATIENT PROFILE

Today's date: \_\_\_\_\_ Initial visit scheduled with (circle one): Dr. Justin Pollack / Dr. Kim Nearpass

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Nickname: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Sex/Gender: \_\_\_\_\_ Preferred pronouns (if any): \_\_\_\_\_

Mailing address: \_\_\_\_\_

Physical address (if different): \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_

May we leave detailed phone messages?  Y  N

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Do you enjoy your job?  Y  N

Would you like to be listed as a supporter of Naturopathic Medicine for our legislative efforts?  Y  N

Does you have a Primary Care Physician (PCP)? Name of PCP: \_\_\_\_\_

Additional health care providers: \_\_\_\_\_

Date of last wellness exam: \_\_\_\_\_ Date of last vision exam: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

Date of last blood work: \_\_\_\_\_ History of abnormal blood work?  Y  N Date: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Please list any **allergies** (medication, food & environmental) & type of reaction: \_\_\_\_\_

*A note to our patients: Naturopathic healthcare is possible only when the physician completely understands the patient's physical, mental and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. This information is kept confidential between you and your doctor. Please answer all questions as completely as possible, and mark anything that you have a question about. Welcome!*

**PRESENT HEALTH CONCERNS:** Please list most important health concerns and goals in their order of significance.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**MEDICATIONS & SUPPLEMENTS**

Please list any supplements, prescription, and/or over-the-counter medications you are currently taking, with dosages:

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**FAMILY HISTORY:**

Mother (age or age of death): \_\_\_\_\_ General health: \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Father (age or age of death): \_\_\_\_\_ General health: \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Have any family members had any of the following conditions? If yes, please specify relationship to you. (M = mother; F = father; PGF = paternal grandfather; MGM = maternal grandmother; S = sibling)

Condition	Yes	Relation	Condition	Yes	Relation
Birth defects			Hearing Loss		
Allergies / Hay fever			Asthma		
Obesity			Anemia / Bleeding disorders		
Diabetes			Heart disease / Stroke		
High cholesterol			High blood pressure		
Liver disease			Gallbladder disease		
Kidney disease			Arthritis / Joint pain		
Autoimmune disorder			Rash / Skin condition		
Epilepsy / seizures			Cancer		
Alcoholism / addiction			Mental illness		

Any other relevant family history? \_\_\_\_\_

**MEDICAL HISTORY:**

Are you adopted?  Y  N If yes, what is your country of origin?

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How would you describe your general state of health? \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

**Vaccination history:**

Date of last tetanus booster (Td/Tdap): \_\_\_\_\_ Do you receive seasonal flu vaccines?  Y  N

**Hospitalizations / surgeries / imaging:**

Please list any surgeries, hospitalizations, injuries or serious illnesses you have experienced with approximate dates:

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Please list any previous imaging studies you have had with approximate dates (X-ray, CT/cat scan, EEG, EKG,

ultrasound, mammogram, etc): \_\_\_\_\_

**SOCIAL HISTORY:**

What is your current living and relationship status? \_\_\_\_\_

Tobacco use: \_\_\_\_\_ Never Smoker \_\_\_\_\_ Former Smoker \_\_\_\_\_ Current smoker \_\_\_\_\_ Packs per day

Do you currently drink alcohol:  Y  N Type & frequency:  
\_\_\_\_\_

Do you currently use marijuana?  Y  N Type & frequency:  
\_\_\_\_\_

Do you currently use recreational drugs:  Y  N Type & frequency:  
\_\_\_\_\_

Do you exercise regularly? Type and frequency: \_\_\_\_\_

**Nutritional History:**

Were you breastfed as a child?  Y  N Delivery method at birth (check one): \_\_\_ Vaginally \_\_\_ Cesarean

Do you follow a specific diet (vegetarian, vegan, gluten-free, etc)?  Y  N \_\_\_\_\_

Do you eat three meals per day?  Y  N Do you have any concerns about your current relationship to foods?  Y  N

Please circle any liquids you drink on a regular basis: Coffee / Caffeinated tea / Caffeine-free tea / Soda / Juice / Water

**REVIEW OF SYSTEMS:** Please circle the correct answer for the conditions listed below as they pertain to *your health*.

*Y = current condition P = past condition*

<b>General</b>					
Height _____	Weight _____	Weight 1 year ago _____	Max weight _____	When _____	
<b>Skin</b>					
Rashes	Y P	Eczema/hives	Y P	Itching	Y P
Acne/boils	Y P	Color changes	Y P	Lumps	Y P
Night sweats	Y P				
<b>Head</b>					
Headache	Y P	Head injury	Y P		
<b>Eyes</b>					
Impaired vision	Y P	Glasses/contacts	Y P	Eye pain	Y P
Tearing/dryness	Y P	Double vision	Y P	Glaucoma	Y P
Cataracts	Y P				
<b>Ears</b>					
Impaired hearing	Y P	Ringings	Y P	Earache	Y P
Dizziness	Y P	Frequent infections	Y P	Herpes	Y P
<b>Nose &amp; Sinuses</b>					
Frequent colds	Y P	Nose bleeds	Y P	Stuffiness	Y P
Hay fever	Y P	Sinus problems	Y P		
<b>Mouth &amp; Throat</b>					
Frequent colds	Y P	Nose bleeds	Y P	Gum problems	Y P
Hoarseness	Y P	Dental cavities	Y P		
<b>Neck</b>					
Lumps	Y P	Swollen glands	Y P		
Goiter	Y P	Pain or stiffness	Y P		
<b>Endocrine</b>					

Hypothyroid	Y P	Hyperthyroid	Y P	Diabetes	Y P
Excessive thirst	Y P	Excessive hunger	Y P	Heat/cold intolerance	Y P

<b>Respiratory</b>
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Cough	Y P	Spitting up blood	Y P	Sputum	Y P
Wheezing	Y P	Asthma	Y P	Bronchitis	Y P
Pneumonia	Y P	Emphysema	Y P	Pleurisy	Y P
Difficult breathing	Y P	Pain on breathing	Y P	Tuberculosis	Y P
		Shortness of breath	Y P		

*Review of systems, continued*

<b>Cardiovascular</b>
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Heart disease	Y P	Angina	Y P	High blood pressure	Y P
Murmurs	Y P	Palpitations	Y P	Rheumatic fever	Y P
Swelling of ankles	Y P	Chest pain	Y P		

<b>Peripheral vascular</b>
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Deep leg pain	Y P	Cold hands/feet	Y P	Varicose veins	Y P
Thrombophlebitis	Y P				

<b>Blood</b>
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Anemia	Y P	Easy bleeding or bruising	Y P
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<b>Gastrointestinal</b>
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Trouble swallowing	Y P	Heartburn	Y P	Change in thirst	Y P
Change in appetite	Y P	Nausea	Y P	Vomiting	Y P
Blood in stool	Y P	Belching/passing gas	Y P	Jaundice (yellow skin)	Y P
Liver disease	Y P	Gall bladder disease	Y P	Ulcer	Y P
Bowel movements:	How often? _____			Is this a change? <input type="checkbox"/> Y <input type="checkbox"/> N	

<b>Urinary</b>
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Pain on urination	Y P	Increased frequency	Y P	Frequency at night	Y P
Inability to hold urine	Y P	Frequent infections	Y P	Kidney stones	Y P

<b>Female Reproductive</b>
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Age menses began: \_\_\_\_\_ Average # of days: \_\_\_\_\_ Length of cycle: \_\_\_\_\_

Bleeding between periods	Y P	Irregular cycles	Y P	Pain during intercourse	Y P
Painful menses	Y P	Excessive flow	Y P	Difficulty conceiving	Y P
Number of pregnancies	_____	Menopausal symptoms	Y P	Sexual difficulties	Y P
Number of live births	_____	Sexually transmitted infections	Y P	Are you sexually active?	Y P
Number of miscarriages	_____	Birth control	Y P	Type of birth control	_____
Number of abortions	_____	Lumps	Y P		
Breast pain or tenderness	Y P	Nipple discharge	Y P	Do you do self-breast exams?	<input type="checkbox"/> Y <input type="checkbox"/> N

Sexual orientation (check one):  Heterosexual  Bisexual  Homosexual  Other \_\_\_\_\_

<b>Male Reproductive</b>
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Hernias	Y P	Testicular masses	Y P	Testicular pain	Y P
Are you sexually active?	Y P	Sexual difficulties	Y P	Prostate disease	Y P
Discharge	Y P	Sexually transmitted infections	Y P	Lesions or sores	Y P

Sexual orientation (check one):  Heterosexual  Bisexual  Homosexual  Other \_\_\_\_\_

<b>Musculoskeletal</b>
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Joint pain or stiffness	Y P	Arthritis	Y P	Broken bones	Y P
Muscle pain/cramps	Y P	Osteoporosis	Y P	Osteopenia	Y P

<b>Neurological</b>
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Fainting	Y P	Seizure	Y P	Paralysis	Y P
Muscle weakness	Y P	Loss of memory	Y P	Numbness/tingling	Y P

<b>Emotional</b>
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Depression	Y P	Anxiety or nervousness	Y P	Disordered eating	Y P
Mood swings	Y P	Tension	Y P	Panic attacks	Y P
Sleep difficulties	Y P	Abuse	Y P	Memory/concentration changes	Y P

*Thank you for taking the time to fill out this form.*

*We look forward to working with you in supporting your health goals!*