

ADULT PATIENT PROFILE

Today's date: _____ Initial visit scheduled with (circle one): Dr. Justin Pollack / Dr. Kim Nearpass / Dr. Eryn J. Scott

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:

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? _____

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:

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

General					
Height	Weight	Weight 1 year ago	Max weight	When	
Skin					
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				
Head					
Headache	Y P	Head injury	Y P		
Eyes					
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				
Ears					
Impaired hearing	Y P	Ringing	Y P	Earache	Y P
Dizziness	Y P	Frequent infections	Y P	Herpes	Y P
Nose & Sinuses					
Frequent colds	Y P	Nose bleeds	Y P	Stuffiness	Y P
Hay fever	Y P	Sinus problems	Y P		
Mouth & Throat					
Frequent colds	Y P	Nose bleeds	Y P	Gum problems	Y P
Hoarseness	Y P	Dental cavities	Y P		
Neck					
Lumps	Y P	Swollen glands	Y P		
Goiter	Y P	Pain or stiffness	Y P		
Endocrine					
Hypothyroid	Y P	Hyperthyroid	Y P	Diabetes	Y P
Excessive thirst	Y P	Excessive hunger	Y P	Heat/cold intolerance	Y P
Respiratory					
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

Cardiovascular					
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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		

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

Blood					
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Anemia	Y P	Easy bleeding or bruising	Y P		
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Gastrointestinal					
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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		

Urinary					
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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

Female Reproductive					
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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):	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Other _____				

Male Reproductive					
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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):	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Other _____				

Musculoskeletal					
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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

Neurological					
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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

Emotional					
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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!