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		

Cardiovascular

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

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

Blood

Anemia	Y P	Easy bleeding or bruising	Y P		

Gastrointestinal

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? □ Y □ N

Urinary

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

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?	□ Y □ N

Sexual orientation (check one): □ Heterosexual □ Bisexual □ Homosexual □ Other _____________________

Male Reproductive

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 _____________________

Musculoskeletal

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

Fainting	Y P	Seizure	Y P	Paralysis	Y P
Muscle weakness	Y P	Loss of memory	Y P	Numbness/tingling	Y P

Emotional

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!