Treat the cause, not the symptoms.
Naturally.

Mountain River
NATUROPATHIC CLINIC

ADULT PATIENT PROFILE

Today's date: ____________

Last Name:______________________________ First Name:_________________________ MI: __________

Nickname:______________________________ Birthdate:______________________ Age:______________

Sex _________________ Preferred pronouns (if any): ____

Mailing address: ____

Physical address (if different): ____

Phone: ____________________________________ Alternate: ______________________________________

Email address: ____

Occupation: ____

What is your current **living and relationship status**? ____

How did you hear about us? ____

Emergency contact name: _____________________________ Relationship: ___________________________

Address: ____ Phone: __________________________________

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

1.____

2.____

3.____

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

____

MEDICATIONS & SUPPLEMENTS

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

____

____

____

LIFESTYLE

Please answer each question from 1 to 10, with 10 being the most	1	2	3	4	5	6	7	8	9	10
How satisfied are you with the health and aliveness of your body?										
How happy are you?										
How anxious, depressed or disturbed do you feel mentally or emotionally?										
How earnestly do you practice to bring about mental-emotional wellness?										
How earnestly you try to care for yourself through the ways you eat?										
How earnestly do you try to care for yourself by working out or exercise?										
How supported do you feel in your most intimate relationship(s)?										
How satisfying is your work or livelihood?										
How satisfying to your financial state?										
How understood and loved do you feel by others?										
How strong is your self-control?										
How kind are you to yourself?										
How satisfying was your childhood?										

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

Do you have any concerns about your current relationship to foods? □ Y □ N ______________________

Do you exercise regularly? Type and frequency: ______________________

Do you drink alcohol: □ Y □ N Type & frequency: ______________________

Do you use marijuana? □ Y □ N Type & frequency: ______________________

Do you use tobacco products? □ Y □ N Type & frequency: ______________________

Do you use recreational drugs: □ Y □ N Type & frequency: ______________________

OTHER PROVIDERS ________**Initial** for authorization to collaborate / share information with specified providers

Do you have a Primary Care Physician (PCP)? Name of PCP: ______________________

Additional health care providers/counselors: ______________________

Date of last blood work: ___________ History of abnormal blood work? □ Y □ N Date: ______________________

Hospitalizations / surgeries / imaging:

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

____

____

FAMILY HISTORY:

Mother (age / age of death): _______ Please describe general health: ______________________

Father (age / age of death): _______ Please describe general health: ______________________

Please list any relevant conditions (heart disease, high cholesterol, diabetes, obesity, addiction, mental illness, allergies, autoimmune conditions, etc.) of close family relatives (brothers, sisters, grandparents, children):

____

____

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

What is your country of origin? ________________________________ Are you adopted? □ Y □ N

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

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!