PACIFIC NATUROPATHIC
MEDICAL CENTER

Today's Date ____________

Contact Information

Name ______________________________ **Age** ________ **DOB** __________

Sex ❑ **M** ❑ **F** **Your relationship status:** ❑**Single** ❑**Married** ❑**Life partner** ❑**Widowed**

Address ____

____

Phone numbers and E-mail (please check numbers to call or leave a message)

❑ **Home** ____________________ ❑ **Cell** ____________________

❑ **Work** ____________________ ❑ **E-mail** ____________________

Children (if applies, please list names and ages)

____________ ____________ ____________

____________ ____________ ____________

Emergency contacts (Name/phone/relationship)

____

____

____

Medical History (for additional information, please attach an additional sheet)

List other doctors and healthcare practitioners you are seeing (name/phone)

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

Prescription drugs and over-the-counter medications you are currently taking

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

Nutrition and herbal supplements you are currently taking (list by brand name, dosage and frequency)

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

Medical History continued…

Health Concerns (please list your concerns in order of importance and describe in detail the history of your symptoms and the effect they have on your life):

____

____

____

____

____

____

____

____

____

Known allergies (drug, food, chemical and environmental)

____

____

____

____

Former Treatments (please list both conventional and alternative treatments you have had and the effectiveness of each treatment)

____

____

____

____

____

____

Date of last physical exam ______________ **Performed by whom?**______________________________

Surgeries and/or hospitalizations (conditions and dates)

____

____

____

____

Serious accidents and/or severe injuries(list any head injuries or broken bones with dates)

____

____

____

____

____

____

Pain Descriptions

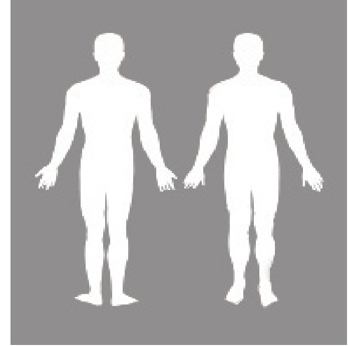

Diagram (mark an **X** on the diagram to indicate where you are currently experiencing pain, numbness and/or tingling)

Rate your PAIN on a scale of 1 to 10 (1=least pain)
How often do you have this pain? __________
Is it consistent or does it come and go? ______________________________

Type of PAIN:
❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other ________________

Activities that are PAINFUL:
❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other ________________

Symptom and Infection History

Have you had the following? (check all that apply)

❑ Alcoholism	❑ Anemia	❑ Anorexia/Bullimia	❑ Psychiatric Care	❑ Diabetes
❑ Arthritis	❑ Asthma	❑ Back Trouble	❑ Ulcers	❑ Epilepsy
❑ Bleeding/Bursting	❑ Blood Transfusion	❑ Breast Lump	❑ Prostate Problems	❑ Migraines
❑ Bronchitis (chronic)	❑ Cancer	❑ Cataracts	❑ Thyroid Disease	❑ Glaucoma
❑ Heart Disease	❑ High Blood Pressure	❑ Kidney Disease	❑ Hemorrhoids	❑ Emphysema
❑ High Cholesterol	❑ Liver Disease	❑ Mitral Valve Prolapse	❑ Low Blood Pressure	❑ Gout
❑ Multiple Sclerosis	❑ Varicose Veins	❑ Hives/Eczema	❑ Hernia	❑ Migraines
❑ Pacemaker	❑ Stroke	❑ Other: __________	__________	__________
❑ AIDS/HIV	❑ Bladder Infections	❑ Bronchitis	❑ Chicken Pox	❑ Diphtheria
❑ Hepatitis	❑ Herpes	❑ Measles	❑ Mono	❑ Mumps
❑ Pneumonia	❑ Polio	❑ Rheumatic Fever	❑ Scarlet Fever	❑ Rubella
❑ Shingles	❑ Typhoid Fever	❑ Tonsillitis	❑ Tuberculosis	❑ Sinusitis
❑ Vaginal Infections	❑ Whooping Cough	❑ Sexually Transmitted		

For Women

Age at first period ______________________
Period frequency (ie; 28 days?) ______________
Days of flow ______________________
Any problems with PMS ______________________
Any irregularities with periods ______________
Last menstrual period ______________________
Extreme menstrual pain? ❑ Yes ❑ No
Any history of infertility? ❑ Yes ❑ No
Any hot flashes or night sweats? ❑ Yes ❑ No
Are you experiencing any sexual dysfunction? ❑ Yes ❑ No

Last pap ______________________
Ever have an abnormal pap? ❑ Yes ❑ No
If YES, describe ______________________
____
Do you do self breast exams? ❑ Yes ❑ No
Last mammogram ______________________
History of breast lump? ❑ Yes ❑ No
If YES, describe ______________________
____

List each pregnancy including abortions, miscarriages and births with dates. If complications with pregnancy or delivery including C-section, please describe: ______________________
____
____
____

For Men

Last prostate exam ______________________ Last PSA ______________________

Number of times you get up at night to urinate ______________________

Are you experiencing any sexual dysfunction? ❑ Yes ❑ No

If YES, describe ______________________

Medical Services

Please indicate the date you last received the following or put N/A for services that do not apply to you.

Tetanus Shot ____________ Flu Shot ____________ Pneumonia Shot ____________

Blood Tests ____________ EKG ____________ Chest X-ray ____________

Colonoscopy ____________ Coronary Calcium Score ____________

Lifestyle

Diet

Do you have any dietary restrictions? ______________________

Do you have any cravings for any particular type of food (be specific) ______________________

____

Are you satisfied with your diet? ❑ Yes ❑ No

If NO, please explain ______________________

How much water do you drink daily? ____________ Other liquids? ____________

What did you eat yesterday? (be specific)

Breakfast ______________________ Snack ____________

Lunch ______________________ Snack ____________

Dinner ______________________

Snack ______________________

Drink

Do you drink alcohol? Indicate what type and what frequency per week ____________

If you used to drink but quit, please indicate date of quitting ____________

Do you drink caffeine? Indicate type and frequency per week ____________

Smoking/Chewing Tobacco and Drugs

If you currently smoke/chew please indicate what you use and frequency per day ____________

Are you a former smoker? Please indicate date of quitting ____________

Do you use recreational drugs? Please indicate type and frequency per week ____________

Weight

Usual weight? ____________ Are you happy with your weight? ❑ Yes ❑ No

Sleep and Exercise

How much sleep do you get per night? ________ Do you feel rested? ❑ Yes ❑ No

Please describe the exercise you do each week and include minutes per session and days per week:

____

Do you enjoy exercise? ______________________

Stress Level and Stress Reduction

Describe your stress level (check one) ❑ NONE ❑ MILD ❑ MODERATE ❑ SEVERE

Describe any stress reduction you practice including minute per session and frequency:

____

____

Lifestyle continued…

Daily and New Routines

Do you enjoy your work/what you do during the day? ____________________

Do you enjoy the people/pets in your life? ____________________

Do you live near an agricultural/industrial area? ____________________

Do you use paint, chemicals or solvents at home, for hobbies or during work? ____________________

Have you moved to a new home recently? ____________________

Have you done any remodeling recently ____________________

Do you have any mold in your home or work area? ____________________

Do you suffer from allergies? ____________________

How many times have you used antibiotics in the past two years? ____________________

List dental history and procedures: ____________________

____

List any cosmetic surgery or procedures ____________________

____

List travel history and vaccinations ____________________

Family History

Please include any family member who has had the following illnesses:

	Relationship		Relationship
❑ Allergies/Asthma		❑ Anemia	
❑ Arthritis		❑ Bleeding	
❑ Cancer		❑ Depression	
❑ Diabetes		❑ Drugs/Alcohol	
❑ Gout		❑ Heart Disease	
❑ High Blood Pressure		❑ High Cholesterol	
❑ Kidney Disease		❑ Mental Illness	
❑ Migraines		❑ Obesity	
❑ Stroke		❑ Thyroid Disease	
❑ Other			

Current status of family members (please include present age, or age and cause at death and if living indicate level of health as good, fair or poor)

Paternal Grandmother ____________________

Paternal Grandfather ____________________

Maternal Grandmother ____________________

Maternal Grandfather ____________________

Father ____________________

Mother ____________________

Siblings ____________________

____

____

Spouse ____________________

Children ____________________

Are you considering Dr. Thoring as your Primary Doctor? ❑ Yes ❑ No

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