

**Alpine Valley Wellness Center, PC**  
430 Elva Way. East Wenatchee, WA 98802 (509) 886-9355

Note: The information you provide is confidential and will be secured via HIPAA regulations. Please complete this questionnaire as thoroughly as possible. Thank you.

Name: \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex:  M  F

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security # \_\_\_\_\_ Family Physician \_\_\_\_\_

Number Household Members \_\_\_\_\_ Highest Education Level \_\_\_\_\_

Known allergies (medications, foods, etc): \_\_\_\_\_

### Current Health Concerns

Please list your present health concerns. Begin with the *most important* to address today.

Date of Onset

- |    |       |       |
|----|-------|-------|
| 1) | _____ | _____ |
| 2) | _____ | _____ |
| 3) | _____ | _____ |

### General information

- | Yes                      | No                       |                                  | Yes                      | No                       |  |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had acupuncture before? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have hepatitis, cancer, or HIV?     |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you bruise easily?            | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a pacemaker?                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you prone to bleed easily?   | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty lying down for 30 minutes?      |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a tendency to faint? | <input type="checkbox"/> | <input type="checkbox"/> | Have you recently traveled outside the US? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nervous about needles?   | <input type="checkbox"/> | <input type="checkbox"/> | Women: are you pregnant?                   |

1. Have you seen a Naturopathic Doctor or Acupuncturist before?  Yes  No Name: Dr. \_\_\_\_\_  
If so, for what condition? \_\_\_\_\_
2. Are you currently seeing a Medical Doctor?  Yes  No Name: Dr. \_\_\_\_\_  
If so, for what condition? \_\_\_\_\_
3. Do you see any other health care professional on a regular basis (Massage, Therapist, Chiropractor, etc)?  Yes  No If so, which type? \_\_\_\_\_
4. Please list the three most significant events in your life, beginning with the most recent. (eg. marriage/ divorce, birth of child, career changes, personal or professional recognition, losses, etc)
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
5. What is your occupation? \_\_\_\_\_ Do you enjoy your work? \_\_\_\_\_
6. Are you currently in a relationship?  Yes  No Sexual orientation:  Heterosexual  Homosexual  Other  
If currently in a relationship:  Married  Significant other  Monogamous  Non-monogamous  
Are you happy/satisfied with your current relationship status?  No  mostly No  mostly Yes  Yes
7. How did you hear about our Clinic? \_\_\_\_\_

## Personal Health Habits

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <i>Yes</i>               | <i>No</i>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Smoker</b> Smoked for _____years    Amount per day_____    Year stopped _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Alcohol</b> Type_____                      Frequency_____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Recreational Drugs:</b> Type_____                      Frequency_____         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Coffee</b> Cups per day: _____ <b>Water:</b> quantity per day: _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Regular exercise</b> If so, describe type and frequency _____                 |

**Height** \_\_\_\_\_    **Current Weight:** \_\_\_\_\_lbs    **Weight 1 year ago:** \_\_\_\_\_lbs    **Maximum weight:** \_\_\_\_\_lbs

**Stress:** What do you currently find most stressful? \_\_\_\_\_

How do you usually deal with stress? \_\_\_\_\_

**Sleep:** Can you sleep uninterrupted through the night? \_\_\_\_\_    How many of hours of sleep? \_\_\_\_\_    Naps? \_\_\_\_\_

**Diet:** History of eating disorders? \_\_\_\_\_    Are you happy with your current diet? \_\_\_\_\_

If not, what would you like to change: \_\_\_\_\_

Please briefly describe the usual items you would have for each meal:

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

Snacks: \_\_\_\_\_

Favorite foods: \_\_\_\_\_

## Medications/Hospitalization

Please list all your prescription **medications** (including sleeping pills, birth control pills), non-prescription medications (such as aspirin, Tylenol, antacids, laxatives, antihistamines), and supplements (i.e. vitamins, herbs, etc.) that you take on a regular basis.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any **hospitalizations, surgery, serious injuries** with the date and type of illness/operation/injury.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Your Medical History

Name: \_\_\_\_\_

Please circle or fill in where indicated if you have ever had any of the following :

AIDS/HIV +	Fatigue, chronic	Mental illness _____
Alcohol abuse	Fibromyalgia	Mononucleosis / Epstein Barr virus
Allergies _____	Female gynecological problems	Mumps
Anemia	Frequent antibiotic use	Panic Attacks
Arthritis	Gall bladder/ Liver problems	Parasites _____
Asthma	Gastrointestinal problems _____	Prostate problems
Back pain	Gum/teeth problems	Rheumatic fever
Bladder/urinary problems	Hair loss	Sexual abuse
Cancer _____	Hayfever	Sexually transmitted diseases (herpes, chlamydia, gonorrhea, etc.) _____
Chest pain	Heart problems _____	Sinusitis
Chickenpox	Hemorrhoids	Skin problems/rashes _____
Colitis/irritable bowel	Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other	Stroke
Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	Hypoglycemia	Tuberculosis
Ear or hearing problems	Impotence/sexual problems	Thyroid problems
Eating Disorders _____	Jaundice	Ulcers
Edema/water weight	Joint problems	<b>Other</b> _____
Epilepsy	Kidney/ Urinary problems	
Eye problems/cataracts/ glaucoma	Measles	

## Family Medical History

For each person below, complete those that are appropriate. Place a **check** in the appropriate column for relevant diseases

	Father	Mother	Brother (s)	Sister (s)	Children	Partner
<b>Age if Living:</b>						
<b>Age at Death:</b>						
<b>Cause of death</b>						
<b>Cancer</b>						
<b>Diabetes</b>						
<b>Depression</b>						
<b>Heart Disease</b>						
<b>High blood pressure</b>						
<b>Stroke</b>						
<b>Epilepsy</b>						
<b>Mental illness</b>						
<b>Asthma</b>						
<b>Kidney Disease</b>						
<b>Glaucoma</b>						
<b>Tuberculosis</b>						
<b>Endocrine Disease (thyroid)</b>						
<b>Multiple Sclerosis</b>						
<b>Neurological Diseases</b>						
<b>Autoimmune Disease</b>						
<b>OTHER (please list)</b>						

## Review of Systems

Please check any of the following that you are experiencing now or have experienced in the past 3 months.

### Energy

- Weary, lethargic
- Decreased libido
- Fatigue
- Poor memory
- Difficulty focusing
- Decreased motivation
- Tend to be warm
- Tend to be cold
- Fevers
- Abnormal sweating

### Sleep

- Difficulty falling asleep
- Difficulty staying asleep
- Wakes in early AM and can't go back to sleep
- Wakes to use bathroom
- Disturbed sleep
- Need naps
- Wakes unrefreshed
- Night sweats
- Other \_\_\_\_\_

### HEENT

- Dizziness/ Vertigo
- Fainting
- Headache/ Migraines
- Facial Pain
- Ringing in the ears
- Poor hearing
- Earaches
- Teeth grinding
- Teeth problems
- Gum problem
- Sores on mouth/lips
- Poor vision
- Blurred vision
- Spots floating in eyes
- Light bothers eyes
- Dry eyes
- Nose bleeds
- Nasal congestion
- Recurrent sore throat
- Other \_\_\_\_\_

### Respiratory

- Daily cough
- Coughing with blood
- Difficulty breathing

- Shortness of breath
- Frequent colds/ flu
- Other \_\_\_\_\_

### Cardiovascular

- High blood pressure
- Low blood pressure
- Irregular heartbeat
- Palpitations
- Chest pain/ pressure
- Varicose veins
- Swelling in hands/ feet
- Other \_\_\_\_\_

### Psychology

- Irritability
- Depression
- Anxiety
- Mood swings
- Increased stress
- Recent loss
- Anger issues
- Fear
- Ongoing worry
- Hyperactivity
- Suicidal thinking
- Other \_\_\_\_\_

### Gastrointestinal

- Nausea/ Vomiting
- Poor appetite
- Food cravings
- Indigestion
- Thirsty: Hot or cold drinks? \_\_\_\_\_
- Abdominal pain
- Flatulence
- Bloating
- Loose stools/ Diarrhea
- Constipation
- Blood or mucus in stool
- Black stool
- Rectal pain
- Other \_\_\_\_\_

### Dermatology

- Acne
- Rashes/ Hives
- Itchy skin
- Dry skin

### Genito-Urinary

- Pain/ Burning with urination
- Urgency to urinate
- Frequent urination
- Difficulty urinating
- Incontinence
- Scanty dark urine
- Abundant pale urination
- History of STD's

### Men

- Last prostate exam \_\_\_\_\_
- Erectile dysfunction/Impotence
- Penile sores/ Discharge
- Other \_\_\_\_\_

### Gynecology

- Pregnancies: \_\_\_\_\_
- Births: \_\_\_\_\_
- Premature/ Miscarry: \_\_\_\_\_
- Stillborn/ Abortion: \_\_\_\_\_
- First menses: \_\_\_\_\_
- Last Pap: \_\_\_\_\_
- Date of last menses: \_\_\_\_\_
- Duration of menses: \_\_\_\_\_
- Days between menses: \_\_\_\_\_
- Vaginal discharge
- PMS
- Breast soreness/ lumps
- Vaginal sores

### Musculoskeletal

- Joint pain/ stiffness
- Muscle weakness
- Bone problems
- Pain
- Where: \_\_\_\_\_
- Better  Worse with pressure
- Better  Worse with heat
- Better  Worse with cold
- Other \_\_\_\_\_

### Neurological

- Seizures
- Spasms
- Paralysis
- Numbness/ tingling
- Loss of consciousness
- Other \_\_\_\_\_

Name: \_\_\_\_\_

**Diet/Nutrition**

- 1) Do you eat five or more "fast food" meals per week? Yes \_\_\_ No \_\_\_
- 2) Do you eat *less* than two portions of fruits and vegetables per day? Yes \_\_\_ No \_\_\_
- 3) Do you react adversely to any food? Yes \_\_\_ No \_\_\_
- 4) Do you regularly consume *more* than two portions of whole-fat dairy products per day (whole milk, cheese, ice cream, butter, etc.) Yes \_\_\_ No \_\_\_
- 5) Do you address weight management by dieting? Yes \_\_\_ No \_\_\_
- 6) Are you on any special diet (vegetarian, dairy-free, etc.)? Yes \_\_\_ No \_\_\_
- 7) Do you have any food cravings? Yes \_\_\_ No \_\_\_
- 8) When missing a meal, do you feel weakness, tremors, nausea, dizziness, irritability, or anxiety? Yes \_\_\_ No \_\_\_
- 9) Do you use artificial sweeteners (e.g. NutraSweet, Sweet&Low) Yes \_\_\_ No \_\_\_

**Genetics**

- 1) Were there medical problems at your birth? Yes \_\_\_ No \_\_\_
- 2) Are there significant diseases that "run in your family"? Yes \_\_\_ No \_\_\_
- 3) Do you have any genetic diseases that you know of? Yes \_\_\_ No \_\_\_
- 4) Any past history of negative reactions to vaccinations? Yes \_\_\_ No \_\_\_

**Environment**

- 1) Do you react adversely when you consume caffeinated beverages? Yes \_\_\_ No \_\_\_
- 2) In your work or home environment, are you exposed to chemicals, cigarette smoke, pesticides, or radiation? Yes \_\_\_ No \_\_\_
- 3) Do you have a history of alcoholism? Yes \_\_\_ No \_\_\_
- 4) Are you sleeping *worse* than you were a year ago? Yes \_\_\_ No \_\_\_

**Psycho-Social**

- 1) Do you feel less happy than you did a year ago? Yes \_\_\_ No \_\_\_
- 2) Do you feel your life has little meaning and/or purpose? Yes \_\_\_ No \_\_\_
- 3) Do you believe stress is presently reducing the quality of your life? Yes \_\_\_ No \_\_\_
- 4) Is your sex life less than satisfactory? Yes \_\_\_ No \_\_\_
- 5) Have you ever been hospitalized for mental or emotional illness? Yes \_\_\_ No \_\_\_
- 6) Is your primary relationship less fulfilling than it was a year ago? Yes \_\_\_ No \_\_\_
- 7) Have you experienced major losses that are negative impacting you? Yes \_\_\_ No \_\_\_
- 8) Do you feel you still have significant issues from your childhood? Yes \_\_\_ No \_\_\_
- 9) Was there a history of alcohol or drug abuse in your family? Yes \_\_\_ No \_\_\_
- 10) Are your current spiritual/religious activities less than satisfactory? Yes \_\_\_ No \_\_\_

**Exercise/Aerobic Conditioning**

- 1) Are your symptoms better with exercise? Yes \_\_\_ No \_\_\_
- 2) Does your present physical condition limit your physical activity? Yes \_\_\_ No \_\_\_
- 3) Do you tend to be warmer or sweat more than others around you? Yes \_\_\_ No \_\_\_

**Women Only**

- 1) Do you experience regular problems with PMS? Yes \_\_\_ No \_\_\_
- 2) Do you regularly have problems with menstrual cramps? Yes \_\_\_ No \_\_\_
- 3) Do you experience irregular menstrual cycles? Yes \_\_\_ No \_\_\_
- 4) Do you experience heavy menstrual periods? Yes \_\_\_ No \_\_\_
- 5) Have you entered menopause? Yes \_\_\_ No \_\_\_
- 6) Do you regularly experience breast problems or nipple discharge? Yes \_\_\_ No \_\_\_

**Men Only**

- 1) Are you currently using anabolic steroids or growth hormone? Yes \_\_\_ No \_\_\_
- 2) Do you have trouble starting your urine, frequent urination pain, or pain in the area of your prostate gland? Yes \_\_\_ No \_\_\_