

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

Telephone _____ Social Security # _____

In case of Emergency, notify: _____ Phone: _____

Current Health Condition

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

	Date of Onset
1) _____	_____
2) _____	_____
3) _____	_____

Has anything recently changed (either better or worse) ? _____

General information

1. Have you seen a Naturopathic Physician before? Yes No In the past ? Yes No
 If yes, whom? _____ For what condition(s)? _____
2. Are you currently seeing a Medical Doctor? Yes No If so, who? _____
 For what condition? _____
3. Have you seen a Doctor of Chiropractic before? Yes No In the past? Yes No
 If yes, whom? _____ For what condition(s)? _____
4. Are you currently seeing any other health care professional? (ie. Acupuncturist, Therapist, etc.)? Yes No If yes,
 whom? _____
5. Please list the three most significant/stressful events in your life ,beginning with the most recent. (eg. Marriage, divorce,
 birth of child, career changes, moving, losses, etc)
 - 1 _____
 - 2 _____
 - 3 _____
6. What is your occupation? _____ Do you like your work? Yes No
7. Are you currently in a relationship? Yes No Is so are you: Married Dating Significant Other
 Are you happy/satisfied with your current relationship status? Yes Mostly Yes No Mostly No
8. How did you hear about our Clinic? _____

Personal Health Habits

Height _____ **Current Weight** _____ lbs **Weight 1 year ago** _____ lbs **Maximum weight** _____ lbs **Year?** _____

Smoker: Yes No **Smoked for** _____ years **Amount per day** _____ **Year stopped** _____

Alcohol: Yes No **Type** _____ **Frequency** _____

Recreational Drugs: Yes No **Type** _____ **Frequency** _____

Coffee: Yes No **Cups per day** _____ **Sodas:** Yes No **Type** _____ **Cans per day** _____

Black Tea: Yes No **Cups per day** _____ **Chocolate:** Yes No **How often?** _____

Regular exercise: Yes No **Describe:** _____

Sleep: **Hours per night** _____ **Is your sleep restful?** Yes No **Do you take sleeping aids?** Yes No

Medications/Hospitalization

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

Please list any known **allergies** you have to drugs, food, or other substances (such as pollen, mold, chemicals, etc.).

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

Is there anything else you would like the doctor to know or address in your treatment?

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	Other _____
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
Age if Living:						
Age at Death:						
Cause of death						
Cancer						
Diabetes						
Depression						
Heart Disease						
High blood pressure						
Stroke						
Epilepsy						
Mental illness						
Asthma						
Kidney Disease						
Glaucoma						
Tuberculosis						
Endocrine Disease (thyroid)						
Multiple Sclerosis						
Neurological Diseases						
Autoimmune Disease						
OTHER (please list)						

Alpine Valley Wellness Center

Jacqueline Thomas, ND

(509) 886-9357

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
- 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 _____