

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

Note: The information you provide is confidential. Please complete this questionnaire as thoroughly as possible.

Name: _____ Age _____ Birth Date _____ Sex: M F

Home Phone: _____ Cell Phone: _____

Family Physician _____

Known allergies (medications, foods, etc): _____

1. Have you seen a Naturopathic Doctor or Acupuncturist before? Yes No Name: Dr. _____
If so, for what condition? _____

2. What is the main issue you would like to discuss today? _____

3. What is your occupation? _____ Do you enjoy your work? _____

4. Are you currently in a relationship? Yes No If currently in a relationship: Married Significant other
Are you happy/satisfied with your current relationship status? No mostly No mostly Yes Yes

5. Do you have a spiritual orientation or religious affiliation? If so, please indicate: _____

Personal Health Habits

<i>Yes</i>	<i>No</i>	
<input type="checkbox"/>	<input type="checkbox"/>	Smoker Smoked for _____ years Amount per day _____ Year stopped _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Type _____ Frequency _____
<input type="checkbox"/>	<input type="checkbox"/>	Recreational Drugs: Type _____ Frequency _____
<input type="checkbox"/>	<input type="checkbox"/>	Coffee Cups per day: _____ Water: quantity per day: _____
<input type="checkbox"/>	<input type="checkbox"/>	Regular exercise 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: Do you sleep well? _____ How many of hours of sleep? _____ Fatigue? _____

Diet: History of eating disorders? _____ Are you happy with your current diet? _____

If not, what would you like to change: _____

Medications/Supplements you are taking: _____

Review of Systems

Please check any of the following that you are experiencing now or have experienced in the past 6 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 _____

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___

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___

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/ Lifestyle

- 1) Are your symptoms better with exercise? Yes___ No___
- 2) Does your present physical condition limit your physical activity? Yes___ No___
- 3) Do you practice any stress reduction (prayer, yoga, meditation, etc.)? Yes___ No___
- 4) Are you sleeping *worse* than you were a year ago? 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___

Consultation Consent

I, the undersigned, authorize Gary Piscopo, ND, L.Ac., to review the information I have provided in order to assist me with an educational consultation. I understand that the consultation will last for 15 minutes and is free – there are no obligations or requirements in order to obtain this consultation.

I further understand that the consultation is educational only and will not provide any diagnosis, lab work, assessment, or treatment of medical issues. If I would like any of these services or if I would like a longer consultations, an appointment will be required.

I understand that there is no implied or stated guarantee of success or effectiveness of any specific treatment or series of treatments suggested. However, the potential benefits from these suggestions could be: relief and resolution of my health concern, reduction and control of pain without the side effects of pharmaceutical intervention (i.e. addiction, mood changes, negative organ effects, etc.), inducement of a greater sense of well being, an enhanced quality of life, and the possibility of the prevention of further health issues.

I hereby release Gary Piscopo, ND, L.Ac. and the Alpine Valley Wellness Center from all liability in connection with the consultation I will receive.

Signature of patient

Date