



19365 S.W. 65th Avenue, Ste. 104 Tualatin, Oregon 97062 Phone: 503-486-5199

Name _____ D.O.B. _____ Gender _____ Marital Status _____ Date _____
(first) (middle) (last)

Address _____ city _____ State _____ Zip Code _____

Home Tel. No. _____ Work Tel. No. _____ E-Mail _____

Cell No. _____

Emergency Contact _____ Tel. No. _____ Relationship _____

How Did You Hear About Me? (Please circle one)

News Paper (if so which one?) _____ Website _____

Other (if so, please explain) _____

1. Please identify the health concerns that have brought you to the clinic below in order of importance:

Condition _____ Past Treatment _____

A. _____

How does this condition affect you? _____

B. _____

How does this condition affect you? _____

2. Do you have any reason to believe that you are pregnant? Y N

3. Do you have any chronic infectious diseases? Y N If yes, please explain. _____

4. Are you currently suffering from any chronic illnesses? Y N If yes, please explain. _____

5. Height _____ Weight _____ Past max. weight _____ When? _____

a. Please indicate typical food intake:

Breakfast: _____ Lunch: _____

Dinner: _____ Snacks: _____

b. Daily Exercise _____ c. Education _____

d. Occupation: _____ Employer: _____ Hours/Week _____

Do you enjoy work? Y N Why/Why Not? _____

f. Nicotine/Alcohol/Caffeine Use: _____

g. Have you experienced any major traumas? Y N h. Television Habits _____

i. Interests & Hobbies: _____

Allergies/Current Medications

Please List Any Allergies And Food Sensitivities

Please Make A List Of All Prescription And OTC Medications

Hospitalizations & Surgeries/X-Ray, CAT Scan, MRI, Special Studies

Hospitalization & Surgery (Reason?)

When?

X-Ray, CAT Scan, MRI, Special Studies (Reason?)

When?



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Emotions							
Are You Often...		No	Yes	Are You Often...		No	Yes
Depressed				Nervous			
Anxious				Jittery			
Irritable				Is Concentration Difficult?			
Review Of Systems							
Please mark with C for current conditions & P for past conditions...							
Fatigue	Pneumonia		Nose bleeds		Heart disease		Ulcers
Slow wound healing	Shortness of breath		Frequent sore throats		Swelling of ankles		Changes in appetite
Chronic infections	Difficulty breathing		Hay fever		Chest pain		Belching
Hypothyroid	Emphysema		Impaired Vision		High B/P		Nausea/ vomiting
Hypoglycemia	Persistent cough		Eye pain/strain		Palpitations		Epigastric pain
Hyperthyroid	Pleurisy		Glaucoma		Stroke		Passing gas
Diabetes Mellitus	Asthma		Glasses/contacts		Heart murmurs		Heart burn
Night sweats	Tuberculosis		Tearing/dryness		Rheumatic fever		Gall bladder disease
Feeling hot /cold	Frequent colds		Neck/shoulder pain		Varicose veins		Liver disease
Frequent urination	TMJ/Jaw Problems		Muscle spasm/cramps		Vertigo/ dizziness		Hepatitis B or C
Blood in urine	Teeth grinding		Arm pain		Paralysis		Hemorrhoids
Frequent UTI	Impaired Hearing		Upper back pain		Numbness		Abdominal pain
Kidney disease	Ear ringing		Mid back pain		Tingling		Diarrhea
Venereal disease	Ear aches		Low back pain		Seizure/epilepsy		Constipation
Painful / difficult urination	Head aches		Leg pain		Loss of balance		Undigested food in the stool
Kidney stones	Sinus problems		Joint pain		Cold hands or feet		Mucous in stool
Eczema/hives	Anemia		Cancer		Rashes		Blood in stool
Male Reproductive							
Do You Now Have Or Have You Ever Had...		No	Yes			No	Yes
Sexual Difficulties				Testicular Pain/Swelling			
Prostate Problems				Penile Discharge			
Female Reproductive							
Do You Now Have Or Have You Ever Had...		No	Yes			No	Yes
Irregular Cycles				Clotting			
Breast Lumps/Tenderness				Menopausal Symptoms			
Nipple Discharge				Difficulty Conceiving			
Heavy Flow				Breast Augmentation			
Vaginal Discharge/Bleeding Between Cycles				Premenstrual Problems			
Age of First Menses?		Birth Control?			Number of Miscarriages?		
Length of Cycle?		Number of Pregnancies?			Number of Abortions?		
Length of Flow?		Number of Live Births?					