CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: _____/_____/_____
(Last Name) (First Name) (Middle Initial)

Preferred Name: _____ Age: _____ Date of Birth: _____ S.S.#: ____XXXXX_____

Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)_____/_(____)_____/_(____)_____
(home) (work) (cell phone or other)

E-mail address: _____ Gender: female _____ male _____

Are you (check one): Single ____ Married ____ Other ____ Partner's Name: _____

Occupation: _____(circle) Full time/ Part time /Student/ Retired

Employer / School: _____

Address: _____/_____/_____/_____
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact _____

(Name) (Relationship)

_(_____)_____(_____)_____
(Day Phone) (Evening Phone)

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).
Is there any place you do **NOT** want me to leave a message? _____

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

May Brandi Owens, RN discuss your private medical information with you via e-mail? □ Yes □ No

By signing below, I verify that the above and below information is correct and true to the best of my knowledge.

Signature of Patient _____ **Today's Date** _____

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: _____Date: _____

What are the concerns for which you are seeking care? (Primary concern first)

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____

Who is your primary care physician? _____
(Name) (Phone if known)

For what concern did you last receive health or medical care? _____

Medications and Supplements

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? _____

_____

_____

Check each that you currently use:

__ Laxatives __ Pain relievers __ Antacids __ Cortisone
__Antibiotics __Heart/Blood medication __Allergy Medication __Thyroid medication
__Sleeping pills __Anti-depressants __Birth Control Pills __Hormones

Do you have any known contagious diseases at this time? □ Yes □ No If yes, what?_____

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current health							
Age at death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer _____ Diabetes _____ Epilepsy _____
Heart Disease _____ High Blood Pressure _____ Stroke _____
Anemia _____ Kidney Disease _____ Glaucoma _____
Allergies _____ Asthma _____ Mental Illness _____
Arthritis _____ Tuberculosis _____ Alzheimer's Dz_____

Name: _____ Date: _____

Have you have any of the following Childhood Illnesses (check if yes)

Scarlet fever ___Diphtheria ____Rheumatic fever ____ Mumps ___Measles ___German measles ___

Have you had any immunizations? □ Yes □ No Negative Reactions? _____

Hospitalizations, Surgery, X-Ray and Special Studies

_____year: _____ _____year: _____

_____year: _____ _____year: _____

_____year: _____ _____year: _____

Allergies

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

_____

General

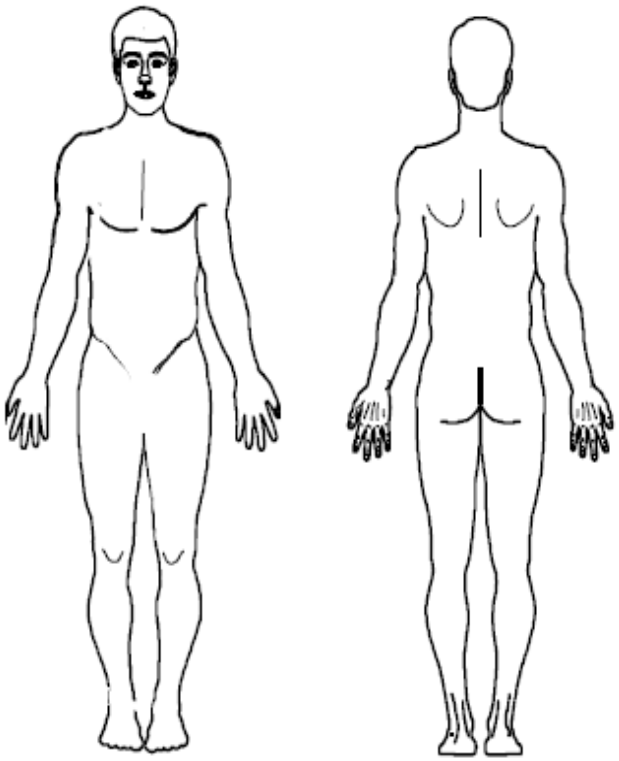
Weight _____lbs. Height_____ Weight 1 year ago _____lbs.

Maximum (non pregnant) Weight _____lbs. When _____

Review of Symptoms

Answer questions or check any of the following you have or have had in the past 6 months.

Please shade in areas where you are experiencing pain on figures (if applicable).



LIFESTYLE HABITS

Main interests and hobbies? _____
Exercise, what kind? _____
How often do you exercise? _____
__Y __ N Have a religious/spiritual practice
__Y __ N Average 6-8 hrs. of sleep
__Y __ N Have a supportive relationship
__Y __ N History of abuse
__Y __ N Major traumas
__Y __ N Use recreational drugs
__Y __ N Treated for drug dependence
__Y __ N Drink coffee
__Y __ N Drink black or green tea
__Y __ N Drink cola or other sodas
__Y __ N Add salt to your food
__Y __ N Eat refined sugar
__Y __ N Enjoy your work
__Y __ N Take vacations
__Y __ N Spend time outside
__Y __ N Watch TV? How much? _____
__Y __ N Read? How often? _____
__Y __ N Use alcoholic beverages
per week _____
__Y __ N Treated for alcoholism
__Y __ N Use tobacco currently
__Y __ N Used tobacco in the past
How many years? ___ Packs per day?____

Name: _____ Date: _____

Review of Symptoms

Check any of the following you have or have had in the past 6 months.

URINARY
___Pain on urination
___Increased frequency
___Frequency at night
___Frequent infections
___Inability to hold urine
___Kidney stones
___Blood in urine

MENTAL/ EMOTIONAL
___Mood Swings
___Anxiety or nervousness
___Considered/Attempted suicide
___Depression
___Poor concentration
___Poor Memory
___Other:_____

GENERAL
___Poor Sleep / Insomnia
___Dream disturbed Sleep
___Fatigue / Low Energy
___General feel Hot
___General feel Cold
___Chills
___Fevers
___Poor Appetite
___Constant Hunger
___Cravings _____
___Peculiar taste in mouth
___Low Libido
___Experience High Stress

MALE ONLY
___Hernias
___Testicular masses
___Testicular pain
___Prostate disease
___Sexually transmitted disease
___Discharge or sores
___Sexual dysfunction
Are you sexually active? Yes No
Sexual orientation? _____
Birth control? Yes No Type? _____

FEMALE ONLY
___Irregular cycles
___Bleeding between cycles
___Pain during intercourse
___Clotting
___Heavy or excessive flow
___PMS
___Endometriosis
___Difficulty conceiving
___Painful menses
___Vaginal discharge? Color? _____
___Vaginal Odor
___Ovarian cysts
___Menopausal symptoms
___Abnormal PAP
___Sexually transmitted disease
___Breast pain/tenderness
___Nipple discharge
___Breast Lumps
Age at which menses began _____
Age of last menses (if menopausal)___
Length of Cycle (Day 1 to Day 1)_____
Duration of Flow _____
Date of last period _____
Are you sexually active? Yes No
Sexual orientation? _____
Birth control? Type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Difficult or premature births? Yes No
If yes explain: _____
Date of last Pap smear _____
Date of last mammogram _____
Could be pregnant now? Yes No
Any other feminine difficulties? _____
Do you do breast self-exams? Yes No

Name: _____ Date: _____

Review of Symptoms

Check any of the following you have or have had in the past 6 months.

SKIN
___Rashes
___Eczema, Hives
___Acne, Boils
___Itching
___Fungal Infections
___Color change
___Hair Loss
___Dry skin / scalp
___Lumps
___Night Sweats
___Slow healing ulcerations
___Flushing or hot flashes

NOSE AND SINUSES
___Frequent colds
___Nose Bleeds
___Stuffiness
___Hay fever
___Sinus problems
___Loss of smell

EYES AND EARS
___Itchy eyes
___Watery eyes
___Dry eyes
___Swollen/painful eyes
___Red Eyes
___Impaired vision/Blurriness
___Floaters in vision
___Cataracts
___Color blindness
___Double Vision
___Glaucoma
___Hearing difficulty
___Ringing
___Earaches/Infection

MOUTH AND THROAT
___Sore throat
___Copious saliva
___Teeth grinding
___Sore tongue/lips
___Gum problems
___Hoarseness
___Gagging/choking
___Difficulty swallowing

HEAD / NECK
___Headache/migraine
___Faintness
___Dizziness
___Jaw Pain
___Swollen Glands
___Goiter
___Pain or stiffness
___TMJ

RESPIRATORY
___Chest congestion
___Wheezing
___Asthma
___Bronchitis/Pneumonia
___Emphysema
___Difficulty/Pain breathing
___Shortness of breath
___Tuberculosis
___Cough ___Wet or ___Dry
___Coughing blood

CARDIOVASCULAR
___Heart disease
___Angina/Chest pain
___High/Low Blood Pressure
___Murmurs
___Blood clots
___Irregular heart beat
___Palpitations/Fluttering
___Swelling in ankles

CIRCULATION
___Easy bleeding or bruising
___Anemia
___Deep leg pain
___Varicose veins
___Cold hands/feet

ENDOCRINE
___Hypothyroid
___Heat or cold intolerance
___Hypoglycemia
___Diabetes
___Excessive thirst
___Excessive hunger
___Fatigue
___Seasonal depression

IMMUNE
___Chronic Fatigue Syndrome
___Chronic infections
___Chronically swollen glands
___Slow wound healing

MUSCLES / JOINTS/ BONES
___Joint pain
___Muscle pain
___Muscle spasms / cramps
___Restless leg Syndrome
___Sciatica
___Osteoporosis

NEUROLOGIC
___Seizures
___Paralysis
___Muscle weakness
___Numbness or tingling
___Easily stressed
___Vertigo or dizziness
___Loss of balance
___Tics

DIGESTION
___Trouble swallowing
___Heartburn / Acid Reflux
___Change in thirst/appetite
___Ulcer
___Nausea/Vomiting
___Gas/Bloating
___Belching or passing gas
___Diarrhea
___Constipation
___Pain or cramps
___Mucous in stools
___Black / Bloody stool
___Hemorrhoids
___Itchy / Burning Anus
___Rectal Pain
___Liver/Gall Bladder trouble
___Jaundice (yellow skin)
Bowel Movements:
How often? ___
Is this a change? _____
Stools ___Hard ___Firm
___Soft ___ Loose

Name: _____ Date: _____

Context of Care Overview

I would like to take a moment to welcome you to my practice. Whether you are here for a one-time visit, or are looking for a longer-term comprehensive health solution, I look forward to my role in your care. Below are a few questions that really assist me in understanding you better and how I can best support your health.

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** 100%

If you answered less than "10", what stands between your current commitment and 100%?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that I will be sharing with you?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What do you love most about your life at this time?

What are your top three expectations of me?

Name: _____ Date: _____

Intake Notes:

Initial Plan of care: