

Anne Hill, ND, AHG
Rising Tide Medicine, PC
503-313-3605

Name _____ Phone(am) _____

Address _____ Phone(pm) _____

E-mail address _____ Date of Birth _____ Age _____

Place of Birth _____ Ethnicity/Nationality _____

Religion/spiritual practice _____ Do you actively practice? _____

Occupation _____ For how long _____ How stressful (on a scale of 1-10) _____

Emergency contact (Name/Address/Phone) _____

What concerns would you like to address? Please indicate how long they have been going on.

1. _____

2. _____

3. _____

What other health related issues have you had in the past? Please include hospitalizations and surgeries

Year/Condition _____

Year/Condition _____

Please mark any illnesses that you have had yourself or that have occurred in any of your blood relatives. Please indicate S for self and O for other. If known, please indicate who and at what age the illness occurred.

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet or Rheumatic Fever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Gout | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Addiction of any kind |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Asthma, Allergies | | <input type="checkbox"/> Glaucoma/Cataracts |
| <input type="checkbox"/> Cancer, what type _____ | | |

CURRENT MEDICATIONS

Medications currently using including prescription, over the counter, herbal and vitamins. Please include how long you have been using them.

Any allergies/adverse reactions to medication? Which ones? _____

Initial Cranial Evaluation:

Assessment and recommendation for treatment: