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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? _____

Color of Hair _____ Color of eyes _____ Height _____ Weight _____

Most you ever weighed as an adult _____ year _____ Least you ever weighed as an adult _____ year _____

Where and when have you lived or traveled outside the U.S.? _____

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

Highest level of education attained _____

Marital status: Single Partnered Married Widowed Divorced No. of times divorced _____

Children: Names and ages _____

Partner's name _____ Partner's occupation _____

Emergency contact (Name/Address/Phone) _____

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

1. _____

2. _____

3. _____

In order to heal these conditions, are you willing to make changes in your lifestyle if necessary? _____

Is another health care practitioner currently treating you? Yes No

Last Physical exam _____ Last dental exam _____

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

Year/Condition _____

Year/Condition _____

Year/Condition _____

FAMILY HISTORY

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

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 _____ | | |

Diet and Nutrition

Please list the times you eat and the types of foods you would eat for a typical....

Breakfast _____ at _____ o'clock

Lunch _____ at _____ o'clock

Dinner _____ at _____ o'clock

Snack _____ at _____ o'clock

What foods do you crave? _____

What foods do you react poorly or are allergic to? _____

How many glasses of water do you drink every day? _____

Do you use now or in the past?	What type?	Amount each day?	For how long
Tobacco			
Alcohol			
Coffee/ black tea			
Soda/carbonated beverages			
Recreational Drugs			

LIFESTYLE

How is your stress level? High ___ Average ___ Low ___ Major Stresses _____

Do you have allergies or sensitivities to medications or other substances? Yes No

List _____

Do you have allergies or sensitivities to any chemicals or environmental toxins? Yes No

List _____

What happens to you when you have an "allergy attack?" _____

What prior types of allergy testing have you had? _____

CURRENT MEDICATIONS

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

Immunizations: Please mark if you have received any of the following

Polio Chicken pox Smallpox TB
Measles, Mumps, Rubella Diphtheria, Pertussis, Tetanus Flu/Influenza

Medical Symptoms Review

Name:

Date:

Directions: Check each symptom that applies at all in the past month. Circle if important now.

Allergy:

- Foods
- Inhalants
- Additives
- Hydrocarbons
- Medicines
- Aspirin
- Asthma
- Eczema

Energy:

- High
- Low
- Normal

Appetite:

- High
- Low
- Normal

Weight:

- Increased
- Decreased
- Unchanged

Headache:

- Dull
- Sharp
- Stabbing
- Pressure
- Band around head
- One side

Frequency:

_____ per month

Duration:

_____ hours

Location:

- Neck
- Temples
- Forehead
- Eyes
- Back of head
- Jaw
- All over head

Muscles and Bones:

- Leg cramps
- Stiff neck
- Neck pain
- Whiplash
- Wry-neck
- Sore, aching muscles
- Low back pain
- Flat feet
- Painful heels
- Loss of muscle power
- Swollen joints
- Painful joints
- Arthritis
- Loss of muscle substance
- Tired feet
- Tired climbing stairs
- Curvature of spine

Skin:

- Heal slowly
- Bruise easily
- Dry
- Oily
- Red around nose
- Acne
- Boils
- Scaly
- Dandruff
- Itchy
- Red spots
- Brown spots
- Varicose veins
- Scalp hair loss
- Body hair loss
- Seborrhea
- Psoriasis
- Brittle nails
- Brittle hair
- Eczema
- Excess hair growth

Hands usually:

- Warm
- Cold
- Wet
- Dry

Eyes:

- Near-sighted
- Far-sighted
- Astigmatic
- Colorblind
- Painful eyeballs
- Halo around light
- Poor night vision
- Glare sensitive
- Inflamed lids
- Sandy feeling in eyes
- Bloodshot
- See double

Ears:

- Loss of hearing
- Hearing too sensitive
- Earache
- Motion sickness
- Dizzy
- Noises in ears

Nose-throat:

- Sinus trouble
- Post-nasal drip
- Hay-fever
- Nosebleed
- Loss of smell
- Strange odors
- Loss of taste
- Metallic taste
- Bad breath
- Sore throat
- Canker sores
- Change in voice
- Hoarseness
- Lump in throat
- Difficulty swallowing
- Grinding teeth in sleep
- Biting tongue
- Tongue-thrusting

Teeth:

- Toothaches
- Tender to cold
- Cavity-prone
- Soft
- Loose
- Dentures

_____ # extractions

Lips:

- Dry
- Chapped
- Peeling
- Split
- Sores at corners

Gums:

- Bleeding
- Infected
- Receding
- Sore

Tongue:

- Dry
- Sore
- Swollen
- Inflamed
- Split
- Loss of taste

Coated:

- White
- Yellow
- Brown
- Black

Digestive:

- Nausea
- Vomiting
- Belching
- Acidity
- Hepatitis
- Ulcer
- Cramps
- Diarrhea
- Constipation
- Gas
- Thin stools
- Mucus stools
- Black stools
- Gray stools
- Bloody stools
- Foul-smelling stools
- Frothy stools
- Rectal spasm
- Hemorrhoids
- Itching anus

Medical Symptoms Review

Digestive (con't):

Laxatives:

_____ # per month

Enema:

_____ # per month

Food intolerance:

- Wheat
- Milk
- Egg
- Citrus
- Fried foods
- Fats
- Yeast

Bowel movements usually

_____ # per week

Chest:

- Cough
- Night sweats
- Painful breathing
- Asthma
- Emphysema
- Bronchitis
- Short of breath
- Green
- Yellow or bloody sputum
- Pleurisy
- Chest pain on exertion
- Irregular pulse
- Rapid pulse
- Palpitation
- Fainting
- Blackout if get up quickly
- Heart murmur
- High blood pressure

Genitourinary:

- Burning urination
- Loss of control of urination

Frequency:

_____ # per day

_____ #per night

- Urgency
- Difficulty starting
- Pain in flank
- Kidney stones

Discolored urine:

- Black
- Brown
- Bloody

- Hernia
- VD
- Lack of sexual information or experience
- Loss of sex drive
- Increase in sex drive

Women only:

Menstrual period

_____ days

Cycle _____ days

Pregnancies _____

Miscarriages _____

Abortions _____

- Menstrual cramps
- Irregular periods
- Nervous before periods

Flow:

- Heavy
- Medium
- Light

- Lack of sexual secretions
- Lack of orgasm
- Vaginal discharge

Date of last pap

smear _____

Men only:

- Loss of erections
- Premature ejaculation
- Sore on penis
- Pain or swelling in groin

Sleep:

Need _____ hours

Get _____ hours

- Slow to fall off
- Early waking
- Restless, light
- Disturbing dreams

Spells:

- Anxiety
- Heart pounding
- Rapid breathing
- Panic
- Weeping
- Depression
- Elation
- Anger
- Nausea
- Irritability
- Poor concentration
- Yawning
- Drowsy
- Trance
- Dizziness
- Misbehavior
- Memory black-out
- Loss of consciousness
- Convulsions
- Weak
- Shaky
- Chills
- Sweats
- Hot flashes

Spells occur:

- Before meals
- After meals
- If hungry
- If upset
- Morning
- Afternoon
- Evening

Nerves:

- Numbness
- Tingling
- Burning
- Shooting pains
- Weakness
- Dropping things
- Stroke
- Tics
- Change in handwriting
- Change in personality
- Loss of memory
- Inability to concentrate
- Tremor
- Sudden jerks of body or extremities
- Twitching in falling asleep
- Loss of balance
- Clumsiness

Cravings:

- Water
- Sweets
- Salt
- Vinegar
- Citrus
- Meat
- Fat
- Eggs
- Dairy
- Alcohol
- Tobacco
- Bread

Medicines used in past month:

- Antibiotic
- Antacid
- Antispasmodic
- Laxative
- Antihistamine
- Codeine
- Muscle relaxant
- Tranquilizer
- Sedative
- Sleeping pill
- Antidepressant
- Stimulants
- Diet pill
- Water pill
- Heart pill
- Thyroid
- Cortisone
- Birth control pill
- Female hormone
- Male hormone
- Asthma medication
- Inhaler
- Nasal decongestant
- Pain pill
- Anticonvulsant
- Aspirin
- Chelation therapy
- HCG injection
- B12 injection
- Vitamin
- Mineral
- Other _____