Eastside
NATURAL MEDICINE

13128 Totem Lake Blvd NE, #104
Kirkland, WA 98034

ph: (425) 814-2045
www.eastsidenaturalmedicine.com

DATE _____

PATIENT PROFILE

Last Name: _____ First Name: _____

Nickname: _____ Birthdate: _____ Sex: _____

A note to our patients : Please complete this questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance.

1. 4.
2. 5.
3. 6.

What goals do you have for your visit at the clinic today? _____

_____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

HEALTH HISTORY:

Please list any severe or life-threatening allergies: _____

Personal Habits:

Please circle any of the following substances that you use regularly: Tobacco Coffee/black tea/cola Alcohol Recreational drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Do you exercise regularly? Yes No What type? _____

How long? _____ How often? _____

Past History:

Hospitalizations: _____

_____

Serious Illnesses and Injuries: _____

_____

Date of last physical/annual exam _____ Date of last blood tests: _____

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PSYCH HISTORY:

Have you ever been touched in a way that made you uncomfortable or was harmful to you without your permission? YES NO

Have you ever been physically or emotionally abused? YES NO

Do you have concerns with abuse or violence in your life now? YES NO

How would you describe your overall wellbeing? _____

_____

PERSONAL AND FAMILY HISTORY:

Please check the "yes" box next to each system that applies to you or one of your family members. Please note what condition in the system applied to family member or you. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	CONDITION		YES	RELATION	CONDITION
Skin				**Urinary**			
Head				**Musculoskeletal**			
Eyes				**Endocrine**			
Ears				**Blood/Lymphatic**			
Nose				**Allergy/Immune**			
Mouth/Throat				**Neurologic**			
Lungs				**Psychologic**			
Heart/Cardio				**Other**			
Stomach/GI							

SOCIAL HISTORY:

Please circle those that apply: Single Married Significant other Widow

Do you have any children? Yes No Please list their age(s) _____