Dr. Tammi Price
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Date:_____

Adult Health Profile

Please answer all questions honestly and with the intent of providing as thorough a picture as possible of your health history.

This form is confidential. This information cannot and will not be given to anyone outside this clinic without your written permission.

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, emotionally, and spiritually.

The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires. If there are ANY questions you prefer not to answer for ANY reason, simply skip the question. Your time, thoughtfulness and honesty are greatly appreciated!

Name:_____ Sex: M F

Address:_____

City:_____ State:_____ Zip:_____

Phone: Home:_____Cell: _____Work:_____ How late can you be called?_____

Email Address:_____Website:_____

Date of birth:_____ Age: _____Blood Type:_____ Ht_____ Wt_____

Race or ethnic background:_____

Education_____Occupation_____ ❒Retired

Employer_____ Hours per week_____

Who can we thank for referring you?_____

Has any other family member already been a patient at the clinic? _____

Emergency contact: _____Relationship_____Phone:_____

Current Health Care Provider(s):	Type:	Phone:	Fax:
_____	_____	(____)_____	(____)_____
_____	_____	(____)_____	(____)_____
_____	_____	(____)_____	(____)_____
_____	_____	(____)_____	(____)_____

Have you ever consulted: ❒Naturopathic Physicians ❒Acupuncturists ❒Chiropractors ❒Nutritionists

❒Other_____

Describe your ideal doctor or healthcare provider:_____

_____

What level of change to your living habits are you willing to make to improve your health and address underlying causes of your signs and symptoms? (0% being no commitment, 100% complete commitment)

0% 10 20 30 40 50 60 70 80 90 100%

What goals do you have for your visit today?

What long term expectations do you have from working with our clinic?

List your major health concerns in order of importance:	Duration:	Severity (1 to 10)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

How did these conditions develop? Are there traumatic events that you can identify as having caused or clearly aggravated your health problems. What happened in your life around this time?

_____

_____

_____

MEDICATIONS:

Do you take or use the following?

Laxatives	Y N
Pain relievers	Y N
Antacids	Y N

List all the drugs (prescription/non-prescription) including dosages.

1. _____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Are you sensitive/allergic to any drugs, foods, chemicals, animals, environmental substances? ❒ Yes ❒ No
If yes, please
list:_____
What happens when you have an "allergy attack"? _____

CURRENT SUPPLEMENTS:

List all vitamins, minerals, herbs, homeopathics, with dosages:

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

PAST MEDICAL HISTORY

Your Prenatal/birth/feeding history:
Any known problems/birth trauma during your mother's pregnancy with you:_____
_____
C-section?_____ Umbilical cord problems?_____ forceps used?____ Antibiotics?_____
Breast fed?_____ how long?_____ Formula (kind):_____how long?_____

What childhood illnesses have you had?

❒Rubella (German 3 day measles)	❒Measles (2 week)	❒Mumps	❒Chickenpox
❒Whooping Cough	❒Rheumatic Fever	❒Polio	❒Scarlet Fever
❒Roseola	❒Asthma	❒Thrush	❒Epilepsy
❒Mononucleosis	❒Strep Throat	❒Ear infections	❒Colic
❒Rashes/cradle cap	❒Constipation	❒Jaundice	❒Headaches

Immunizations: ❒Polio ❒Tetanus ❒Measles/Mumps/Rubella ❒Pertussis ❒Diptheria
❒Hepatitis B ❒chicken pox ❒H. influenzae ❒Flu shot ❒Other (for travel)_____

Major Illnesses/emotional or physical trauma/ accidents (not already listed):

Type:	Date:	Treatment received:	Outcome:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Outpatient Procedures / Hospitalizations, surgeries/ special diagnostic studies:

Type (of surgery/study)	Date	Reason for procedure/ admission	Outcome / Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

❒Recent physical exam: Date_____ Results: _____ ❒normal
❒ Recent blood work/ urine test: Date_____ Results:_____ ❒normal
❒Recent PAP/ pelvic or prostate exam: Date_____Results:_____❒normal
❒Recent mammogram (females over 40):Date _____ Results:_____❒normal

LIFESTYLE:

Are you currently: ❒Single ❒Married ❒Partnership ❒Separated ❒Divorced ❒Widowed

Live with: ❒Spouse ❒Partner ❒Parents ❒Children ❒Friends ❒Alone

Are you sexually active? (circle one) ❒Yes ❒No If yes, is it with (circle one): male female both

Do you or your partner(s) use any form of contraception? ❒Yes ❒No If so, what type(s)?_____

Are you pregnant? ❒Yes ❒No Trying to get pregnant? ❒Yes ❒No If so, how far along ?_____

Do you have children? ❒Yes ❒No How many? _____ Names/ ages/ and health or wellness issues:

_____

How would you describe your general health? _____
Are you happy in your job or career? Yes No _____
_____
What personal goals do you have?_____
What makes you happy?_____
What are you grateful for?_____
What is your individual & unique purpose in this life?_____
Religious/spiritual affiliation_____
What would you like to change most about your life?_____
_____
What behaviors, habits, or thoughts would you like to eliminate?_____
_____
Is your present sex life satisfactory? _____
Do you drink alcohol? ❒ Yes ❒No How often?: wine_____beer_____other alcohol_____
Do you use tobacco or have you in the past? ❒ No ❒ Yes, How long? _____ how much daily?_____
Do you now or have you in the past used recreational drugs? ❒ Yes ❒ No _____
Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins? ❒ Yes ❒ No
If yes, please explain_____
_____
Do you exercise? ❒ Yes ❒ No What form(s)?_____
How often?_____
Do you make time for rest, relaxation or meditation during the day and/or before bed? ❒Yes ❒No
How often? _____How do you relax?_____
What are your interests or hobbies?_____
Which of the following do you do regularly: ❒Jogging ❒Swimming ❒Walking ❒Biking ❒Gardening
❒Yoga ❒Breathing Exercises ❒Meditation ❒Weightlifting ❒Pilates ❒Pray
❒Other activities: _____
Do you use regularly? ❒Electric Hair dryer ❒Electric Blanket ❒Heating pad ❒Cosmetics, Perfumes
Are your home and/or work environments well ventilated? ❒Yes ❒No Mold? ❒Yes ❒No
Are there unusual/unpleasant smells in your work/living environment? ❒Yes ❒No
When were the ducts in your home last cleaned?_____

DIET:

How many meals do you generally eat each day? ❒One ❒Two ❒Three ❒More than three
Do you: ___eat out often ___diet frequently ___skip meals frequently
Do you have any special diet or eating restrictions? ❒Yes ❒No if yes, please explain_____
_____
List the primary foods you include in your diet?_____
List the foods you exclude from your diet_____
Mark which of these you consume regularly. ❒Coffee ❒Caffeinated teas ❒Artificial sweeteners
❒Processed foods ❒Preservatives ❒Refined foods ❒Margarine ❒Fast Food Sugar/sweets
List any other foods you eat which you suspect may be harmful to your health_____
List any foods you crave, regardless of their nutritional value (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.)_____
List any foods to which you have a bad reaction:_____
Are you thirsty often? ❒Yes ❒No at night? ❒Yes ❒No How much water do you drink daily?_____
What temperature do you prefer to drink? ❒Hot ❒Cold ❒Room Temp.
Are you satisfied with your diet as it is now? ❒Yes ❒No If no, why not?_____

SLEEP:

Do you have trouble falling asleep? ❒Yes ❒No If yes, what keeps you up?_____

_____

Do you wake at night and can't fall back to sleep? ❒Yes ❒No_____

Do you wake feeling refreshed? ❒Yes ❒No_____

Do you have recurring dreams? ❒Yes ❒No If yes, what is the theme?_____

_____

FAMILY MEDICAL HISTORY:

(Please list ages and if deceased, what they passed from and at what age)

Mother's Side

Grandfather_____

Grandmother_____

Mother_____

Father's Side

Grandfather_____

Grandmother_____

Father_____

Your Sisters _____

Your Brothers _____

Has any BLOOD RELATIVE had any of the following:

❒Anemia	❒Kidney Disease	❒Arthritis
❒Heart Disease	❒Mental Illness ( )	❒Autoimmune Condition
❒Asthma/Hay Fever/Hives	❒High Blood Pressure	❒Alzheimers
❒Bleeding Disorder	❒Seizure/Epilepsy	❒Alcoholism/Addiction
❒Cancer	❒Sickle Cell/Thalassemia	❒Obesity
❒Diabetes	❒High Cholesterol	❒Osteoporosis
❒Thyroid (hyper/hypo)	❒Liver Disease	❒Glaucoma
❒Eczema	❒Tuberculosis (TB)	❒Stroke

General Status:

Listed below are factors which may or may not influence your state of being. Please check the appropriate box of ONLY those with SIGNIFICANT influence on your health.

BETTER	WORSE		BETTER	WORSE
		Winter		Spring
		Summer		Autumn
		Cold		Heat
		Dampness		Dryness
		Open air (being outside)		Windows closed
		Change of weather		Traveling
		Ocean seashore		Mountains
		Physical exertion		Upon rising
		Morning		Evening
		Cold application		Warm application
		Bath		Before menstruation
		During menstruation		After menstruation

Weight _____ lbs. Weight 1 year ago _____ lbs.

Maximum Weight _____ When _____

Height _____

When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you have now N = never had P = a condition you have had before

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Considered/Attempted suicide?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N
Fears/phobias?_____	Y P N	Post Traumatic Stress Syndrome	Y P N

ENDOCRINE

Hypo/Hyperthyroid? (circle)	Y P N	Heat or cold intolerance? (circle)	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

IMMUNE

Vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

NEUROLOGIC

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Easily stressed?	Y P N
Vertigo or dizziness?	Y P N	Loss of balance/fainting?	Y P N
Tremor (shaking/trembling)?	Y P N	Temporary loss of sensation?	Y P N

SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N	Night Sweats?	Y P N

HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N	Nose Bleeds?	Y P N
Stuffiness?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

RESPIRATORY

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath?	Y P N
Shortness of breath at night?	Y P N	" " " " " "lying down?	Y P N
Tuberculosis?	Y P N		

CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles?	Y P N		

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel Movements: How often? _____	
Blood in stool?	Y P N	Is this a change?_____	
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness?	Y P N	Arthritis?	Y P N
Broken bones?	Y P N	Weakness?	Y P N
Muscle spasms or cramps?	Y P N	Sciatica?	Y P N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y P N	Anemia?	Y P N
Deep leg pain?	Y P N	Cold hands/feet?	Y P N
Varicose veins?	Y P N	Thrombophlebitis?	Y P N

MALE REPRODUCTION

Hernias?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Venereal disease?	Y P N	Discharge or sores?	Y P N
Are you sexually active?	Y N	Chlamydia?	Y P N
Sexual orientation: _____		Gonorrhea?	Y P N
Impotence?	Y P N	Condyloma?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N
Birth control? Type? _____		Syphilis?	Y P N

FEMALE REPRODUCTION/BREASTS

Age of first menses? _____

Age of last mense? _____		Are cycles regular?	Y N
Length of cycle? _____	days	Bleeding between cycles?	Y P N
Duration of menses? _____	days	Pain during intercourse?	Y P N
Painful menses?	Y P N	Clotting?	Y P N
Heavy or excessive flow?	Y P N	Discharge?	Y P N
PMS?	pY P N	Birth control?	Y P N

If yes, what are your symptoms? What type? _____

_____ Number of pregnancies _____

_____ Number of live births _____

Endometriosis?	Y P N	Number of miscarriages _____	
Ovarian cysts?	Y P N	Number of abortions _____	
Difficulty conceiving?	Y P N	Menopausal symptoms?	Y P N
Cervical Dysplasia?	Y P N	Abnormal PAP?	Y P N
Sexual difficulties?	Y P N	Chlamydia?	Y P N
Gonorrhea?	Y P N	Condyloma?	Y P N
Herpes?	Y P N	Syphilis?	Y P N
Are you sexually active?	Y N	Sexual orientation: _____	
Do you do breast self exams?	Y P N	Breast lumps?	Y P N
Breast pain/tenderness?	Y P N	Nipple discharge?	Y P N

Welcome! I look forward to working with you! If you have any questions, please ask!