

Thank you for taking the time to care for yourself! Successful health care and preventive medicine are possible only when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please answer the following questions as completely as possible. The information you provide will help Dr. Alysa Nguyen create a holistic treatment plan specified to your individual needs.

CONFIDENTIAL PATIENT PROFILE

Date: _____

Name: _____ Age: _____ Birth Date: _____ Gender: Male Female

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Where can messages be left for you: Home Work Cell

Email: _____ Would you like to receive a free e-newsletter? _____

Occupation: _____ Employer: _____

Name of Emergency Contact & relationship: _____ Phone: _____

Marital status: Married Single Divorced Widowed Number of children: _____

How did you hear about our health clinic? Google Yahoo Website Specify: _____

Person responsible for payment: _____

Insurance information: _____ Does your insurance reimburse for Naturopathic care: Y N

Does your insurance reimburse for Acupuncture: Y N

Do you have a health savings account (HSA)? Y N

What goals would you like to achieve in regards to your overall health?

In 4 to 6 months _____

In 1 to 2 years _____

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 -10, with 10 being 100% committed)

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

Present Health Concerns: Please list your most important health concerns in their order of priority and date started.

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

What forms of treatment have you sought for your main health concerns?

List 3 things that come to mind that would prevent you from reaching your health goals:

Please list your current health care providers:

Name	Type	For what reason	Phone (if available)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations, serious illnesses, injuries, and surgeries: (Please list reason and dates)

Date of last full physical exam: _____ Results: normal other: _____

Date of last blood work: _____ Results: normal other: _____

Please list any prescription or over-the-counter medications that you are currently taking:

Name of drug	Dose	Reason for taking	For how long	Who prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any vitamins, minerals, herbs or homeopathic remedies that you are presently taking & brand:

Name of supplement	Dose	Reason for taking	For how long	Who prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications? _____

Are you allergic to any foods or other substances that you know of? _____

Lifestyle Habits:

Tobacco:	<input type="checkbox"/> None	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Amount? _____
Coffee:	<input type="checkbox"/> None	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Amount? _____
Black tea:	<input type="checkbox"/> None	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Amount? _____
Soft drinks:	<input type="checkbox"/> None	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Amount? _____
Alcohol:	<input type="checkbox"/> None	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Amount? _____
Recreational drugs:	<input type="checkbox"/> None	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Amount? _____
Exercise:	<input type="checkbox"/> None	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Amount? _____

Diet: Please describe your typical diet (breakfast, lunch, and dinner), including any guidelines or restrictions that you follow:

Breakfast: _____

Lunch: _____

Dinner: _____

Guidelines/Restrictions: _____

Water intake: _____

Do you crave certain kinds of foods and what kind? _____

Sleep: Hours of sleep per night? _____ Any problems with sleep? _____
 How often in a week do you wake up feeling refreshed? _____
Energy: Energy level on a scale of 1-10 (1 means you cannot get up, 10 means optimal full energy)? _____
Appetite: How is your appetite on a scale of 0-10? (0 means you have no appetite, 10 means voracious appetite)? _____
Mood: How would you describe your day-to-day mood? _____

PERSONAL HEALTH HISTORY: The following is a list of symptoms that you may have or never had. Please indicate as follow:

check mark = **experience currently(C)** and often **P** = experience in **Past** **N** = no mark **Never experience**

<p>GENERAL Height _____ Weight _____ Weight changes: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual weight change</p> <p>SKIN <input type="checkbox"/> Rashes (l) <input type="checkbox"/> Growths <input type="checkbox"/> Soft or brittle nails <input type="checkbox"/> Acne <input type="checkbox"/> Infections</p> <p>EYES <input type="checkbox"/> Corrective vision <input type="checkbox"/> Change in vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Tearing or dryness <input type="checkbox"/> Floaters (h,l) <input type="checkbox"/> Decreased night vision</p> <p>HEART <input type="checkbox"/> Heart disease <input type="checkbox"/> Low/High blood pressure <input type="checkbox"/> Chest pain (h,l) <input type="checkbox"/> Palpitations, fluttering <input type="checkbox"/> High cholesterol <input type="checkbox"/> Sores on tip of tongue <input type="checkbox"/> Restlessness <input type="checkbox"/> Frequent dreams <input type="checkbox"/> Anxiety or nervousness <input type="checkbox"/> Nightmares <input type="checkbox"/> Mental confusion <input type="checkbox"/> Swelling in ankles <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> Deep leg pain <input type="checkbox"/> Varicose veins <input type="checkbox"/> Cold hands and or feet (h,k)</p>	<p>KIDNEYS /URINARY <input type="checkbox"/> Afternoon hot flushes <input type="checkbox"/> Night sweats <input type="checkbox"/> Heat in the hands, feet, chest <input type="checkbox"/> Edema <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Kidney stones <input type="checkbox"/> Excessive hair loss (l, k) <input type="checkbox"/> Urination at night <input type="checkbox"/> Fear <input type="checkbox"/> Pain on urination <input type="checkbox"/> Increased frequency <input type="checkbox"/> Inability to hold urine <input type="checkbox"/> Bladder infections</p> <p>LUNGS, NOSE, SINUSES <input type="checkbox"/> Pain on breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Decreased sense of smell <input type="checkbox"/> Positive TB test ever? <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent colds <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus problems <input type="checkbox"/> Allergies <input type="checkbox"/> Chronic daily fatigue & malaise <input type="checkbox"/> Feel worst after exercise <input type="checkbox"/> Difficulty keeping eyes open <input type="checkbox"/> Dry skin <input type="checkbox"/> Sadness <input type="checkbox"/> Frequent sore throat</p>	<p>STOMACH/LI <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Indigestion <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Bloating after eating <input type="checkbox"/> Belching or burping <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Canker sores (mouth) <input type="checkbox"/> Stomach pain/upset <input type="checkbox"/> Bleeding/swollen/painful gums <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools</p> <p>ENDOCRINE/SPLEEN <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Tendency to faint easily <input type="checkbox"/> Low appetite <input type="checkbox"/> Easy weight gain <input type="checkbox"/> Abdominal gas/bloating <input type="checkbox"/> Fatigue after eating <input type="checkbox"/> Loose stools/diarrhea <input type="checkbox"/> Undigested food in stools <input type="checkbox"/> Prolapsed organs <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bleeding or bruising <input type="checkbox"/> Mental foginess <input type="checkbox"/> Depression</p>	<p>LIVER/GALLBLADDER <input type="checkbox"/> Gallstones <input type="checkbox"/> Jaundice (yellow eyes or skin) <input type="checkbox"/> Difficulty digesting oily foods <input type="checkbox"/> Difficulty in making plans/decisions <input type="checkbox"/> Anger easily <input type="checkbox"/> Irritability <input type="checkbox"/> Bitter taste in the mouth <input type="checkbox"/> Metallic taste in the mouth <input type="checkbox"/> Muscle spasms or cramps <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Seizures <input type="checkbox"/> Mood swings <input type="checkbox"/> Tension <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Fainting <input type="checkbox"/> Paralysis <input type="checkbox"/> Loss of memory</p> <p>MUSCULOSKELETAL <input type="checkbox"/> Joint pain or stiffness <input type="checkbox"/> Broken bones <input type="checkbox"/> Shoulder tension <input type="checkbox"/> Low back pain <input type="checkbox"/> Knee problems</p> <p>NECK/HEAD <input type="checkbox"/> Swollen glands <input type="checkbox"/> Neck pain or stiffness <input type="checkbox"/> Headache <input type="checkbox"/> Head Injury <input type="checkbox"/> Dizziness</p>
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MALE HEALTH HISTORY:

Hernias Testicular pain Venereal disease Prostate problems
 Testicular masses Discharge or sores Difficulty w/ urination

Date of last prostate exam _____
 Results: normal other: _____

FEMALE HEALTH HISTORY:

MENSTRUAL HISTORY

Age menses began _____
 Date & Age menses ended _____
 Are cycles regular currently? Y N
 Have your cycles changed since they began? Y N
 Describe if Yes _____

No. of days menstrual flow _____
 No. of days between periods _____
 PMS C P N
 Bleeding between periods C P N
 Excessive flow C P N
 Cramps C P N

Date of last Pap smear: _____
 Results: normal other _____
 Ever had an abnormal Pap? Y N When: _____
 Abnormal vaginal discharge C P N
 Ever used birth control pills? C P N
 If so, how long and what kind? _____

Menopausal symptoms C P N
 Ever use hormone replacement therapy? If yes, describe what kind and when _____

BREASTS

Do you do regular self-exams? Y N
 Lumps C P N
 Pain or tenderness C P N
 Nipple discharge C P N

Date of last mammogram: _____
 Results: normal other _____

Are you trying to get pregnant? Y N
 Are you pregnant, or is there any chance that you are pregnant? _____
 No. of pregnancies _____ No. of live births _____
 No. of miscarriages _____ No. of abortions _____

Do you have or have you had any of the following?
Please check & describe when:

fibroids cervical polyps ovarian cysts hernias
 cervicitis chlyamdia gonorrhea
 candidiasis/yeast infection hysterectomy HPV
 When: _____

PERSONAL and FAMILY HISTORY: Please indicate any significant illnesses you or a blood relative has had.

	You	Family	Date		You	Family	Date
Alcoholism/drug addictions				Hepatitis			
Allergies				Mental illness			
Arthritis				Osteoporosis			
Asthma				Thyroid problems			
Cancer				Parkinson's disease			
Depression				Alzheimer's disease			
Diabetes				Obesity			
Epilepsy				Heart disease, stroke, high blood pressure, heart attack			

List any other personal history of any illnesses: _____
 Sexually Transmitted Diseases: AIDS HERPES HPV Syphilis Date _____

Any other relevant family history including living status of blood relatives (i.e deceased due to illness or natural cause)
