CENTRE DOWNE HEALTH LLC

Naturopathic Family Medicine and Acupuncture

Dr. Brian Paterson, ND, Lac and Dr. Kathryn Cranford, ND, NHCM

PERSONAL CONTACT INFORMATION

All contact information is for professional use only and will be held in strict confidence.

Name _____ Date of Birth _____ Age _____ Gender M F

Address _____ City _____ State _____ ZIP _____

Home # _____ Cell # _____ SSN# _____-___-_____

Email _____ I would like to receive CDH e-newsletters Y N

Occupation _____ Employer _____ Work # _____

Marital/Relationship Status _____ Spouse/Partner's name _____

Emergency contact _____ Relationship _____ Ph. # _____

Insurance: _____ ID#_____ Group# _____
Secondary Insurance: _____ ID#_____ Group# _____

Do you have a Primary Care Doctor? Y N If yes, please provide the following information:
Doctor's Name _____
Clinic Address _____
Office # _____ Office Fax # _____

Other current health care practitioners:
Name/discipline: Address: Phone #:

_____
_____
_____

Who may we thank for referring you to CDH? _____

PRESENT HEALTH CONCERNS:

Please list your health concerns in the order of their significance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

What other treatments have you tried?

_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

Had condition in past?					Had in past?		Vaccinated?	
	Yes	**No**	**# of times/details**		**Yes**	**No**	**Yes**	**No**
ADD/ADHD				Chicken Pox (Varicella)				
Allergies				Diphtheria				
Asthma				German Measles				
Bronchitis				Pertussis				
Ear Infections				Polio				
Eczema				Rheumatic Fever				
Strep Throat				Rubella				
Tonsillitis				Scarlet Fever				

Please list any hospitalizations, surgeries, x-rays, and other imaging:
Procedure Year Dr./Facility Reason/Outcome

_____
_____
_____
_____

Known Allergic Reactions: (Drugs, Pollens, Foods, other)
Item reacted to: What was the reaction?:

_____
_____
_____
_____
_____

CURRENT MEDICATIONS: herbs, vitamins, contraceptives, pharmaceuticals Please attach a complete list if this is not enough space for everything you are taking			
Medication/supplement name	**Dose (how much)**	**Frequency (how often)**	**For how long?**

FAMILY INFORMATION (optional)			
Children's names	**Gender**	**Age**	**Date of birth**

ADULT SYMPTOM SURVEY

Height_____ Ideal/Preferred Weight_____ Usual Weight_____ Current Weight_____

This survey will help us to evaluate you more completely. Please place a **check mark** next to those symptoms which you **NOW** experience or have experienced in the **PAST**. Include all the complaints which are familiar to you. If there are one or more words in a line which describe your specific problem, **please circle the words that best describe your symptom**.

NOW	PAST	GENERAL SYMPTOMS
_____	_____	fatigue, weak, lack of energy
_____	_____	insomnia or sleep too much
_____	_____	sensitive or shy
_____	_____	worry, anxiety, nervousness, irritability
_____	_____	difficulty making decisions
_____	_____	poor memory, concentration
_____	_____	depression, melancholy, moodiness
_____	_____	Overwhelm, hopeless feeling
_____	_____	persistent or frightening thoughts
_____	_____	considered suicide
_____	_____	poor immunity, frequent colds or illnesses
_____	_____	headaches/migraines
_____	_____	don't sweat enough, sweat too much
_____	_____	night sweats
_____	_____	dizziness, fainting, convulsions
_____	_____	balance loss
_____	_____	loss or gain of weight
_____	_____	other:_____

NOW	PAST	EYES/VISION
_____	_____	wear glasses and/or contacts
_____	_____	nearsightedness or farsightedness
_____	_____	double vision
_____	_____	sees halos, lights, colors
_____	_____	has had eye correction surgery
_____	_____	blurred or failing vision
_____	_____	reduced field of vision
_____	_____	floaters or spots in visual field
_____	_____	burning, dry or itchy eyes
_____	_____	eyes water excessively
_____	_____	sensitivity to light
_____	_____	night blindness
_____	_____	bloodshot or puffy eyes

NOW	PAST	RESPIRATORY
_____	_____	cough frequently
_____	_____	spitting up mucus or blood
_____	_____	difficulty breathing
_____	_____	shortness of breath on exertion
_____	_____	chest pain
_____	_____	frequent respiratory infections
_____	_____	other:_____

NOW	PAST	SKIN AND HAIR
_____	_____	acne or pimples
_____	_____	skin rashes
_____	_____	hives
_____	_____	stretch marks
_____	_____	skin ulcers or sores
_____	_____	dryness, roughness, scaling skin:
_____	_____	on scalp, elbows, knees, feet
_____	_____	around nose ears, eyebrows, etc.
_____	_____	hair loss or thinning
_____	_____	dry, coarse hair or split ends
_____	_____	bruise easily
_____	_____	nails weak, ridged or split easily
_____	_____	brown spots or bronzing on skin
_____	_____	moles, warts or skin tags
_____	_____	sunburn easily
_____	_____	cuts heal slowly or scar badly
_____	_____	flush easily
_____	_____	swollen neck or glands
_____	_____	hands or feet numb, tingling, burning
_____	_____	difficulty swallowing
_____	_____	athlete's foot
_____	_____	other:_____

NOW	PAST	EAR/NOSE/THROAT
_____	_____	earaches
_____	_____	noise or ringing in the ear
_____	_____	discharge from the ear
_____	_____	excessive ear wax
_____	_____	loss of hearing
_____	_____	hay-fever, allergies, runny nose
_____	_____	sinusitis, sinus infection
_____	_____	dry mouth or nose
_____	_____	frequent nosebleeds
_____	_____	cracks in corners of mouth
_____	_____	dry or chapped lips
_____	_____	frequent sore throat or tonsillitis
_____	_____	clear throat often/hoarse voice
_____	_____	sore, red or cracked tongue
_____	_____	over- or in-sensitive to smell or taste
_____	_____	dental issues, cavities, TMJ
_____	_____	sore/bleeding gums
_____	_____	other:_____

NOW	PAST	GASTROINTESTINAL
_____	_____	loss of appetite
_____	_____	gagging, difficulty swallowing
_____	_____	nausea or vomiting
_____	_____	halitosis (bad breath)
_____	_____	metallic or bitter taste in mouth
_____	_____	food cravings or strong desires
_____	_____	avoid certain foods, food aversions
_____	_____	can't digest fats
_____	_____	heartburn/reflux
_____	_____	indigestion or gastrointestinal distress
_____	_____	heaviness after eating
_____	_____	frequent belching or gas
_____	_____	abdominal bloating
_____	_____	stomach or abdomen tender or painful
_____	_____	symptoms relieved by eating
_____	_____	symptoms worsened after eating
_____	_____	headache, dizzy, irritable if skip meal
_____	_____	diarrhea, loose stools
_____	_____	constipation
_____	_____	recent change in bowel movements
_____	_____	light colored or greasy stools
_____	_____	dark stools or blood in stool
_____	_____	feeling of incomplete evacuation
_____	_____	mucus or undigested food in stool
_____	_____	foul odor of stool or gas
_____	_____	hemorrhoids, bleeding or swollen
_____	_____	other:_____

NOW	PAST	CARDIOVASCULAR
_____	_____	heart beats fast or irregularly
_____	_____	tightness or pain in chest
_____	_____	discomfort at high altitude
_____	_____	dizzy or weak upon standing up
_____	_____	swollen feet, ankles or legs
_____	_____	cold hands or feet
_____	_____	hands of feet turn blue
_____	_____	blue fingernails
_____	_____	leg pain while walking
_____	_____	varicose veins
_____	_____	easy or excessive bruising or bleeding
_____	_____	tendency to anemia
_____	_____	high blood pressure
_____	_____	low blood pressure
_____	_____	other:_____

NOW	PAST	MALE REPRODUCTIVE
_____	_____	prostate problems
_____	_____	difficult or unusual urination
_____	_____	discomfort or pain in genital area
_____	_____	burning/discharge
_____	_____	lumps, swelling, pain in testicles/scrotum
_____	_____	difficulty getting or maintaining an erection
_____	_____	premature ejaculation
_____	_____	diminished sexual desire
_____	_____	excessive sexual desire

NOW	PAST	MUSCULOSKELETAL
_____	_____	muscle aches, pain or stiffness
_____	_____	joint pain, swelling, stiffness
_____	_____	bone pains
_____	_____	painful feet, ankles, calves
_____	_____	tremors, twitches
_____	_____	weakness, loss of strength
_____	_____	hernia
_____	_____	muscle wasting
_____	_____	paralysis

Location of symptom listed:

Head:_____
Neck:_____
Shoulders: R L _____
Arms: R L _____
Wrists: R L _____
Fingers: R L, 1 2 3 4 thumb _____
Torso:_____
Back: upper, mid, low _____
Hips: R L _____
Knees: R L _____
Ankles: R L _____
Legs: R L _____
Feet: R L top, bottom _____
Toes: R L big 2 3 4 5 _____

NOW	PAST	FEMALE REPRODUCTIVE
_____	_____	irregular menstruation
_____	_____	pain prior to or with menses
_____	_____	depressed, tense or irritable around menses
_____	_____	painful or swollen breasts
_____	_____	lumps in breasts
_____	_____	discharge from nipples
_____	_____	symptoms occur in monthly pattern
_____	_____	pain, discomfort, itching in genital area
_____	_____	unusual color/odor/amount vaginal discharge
_____	_____	uterine fibroids
_____	_____	hot flashes or other menopausal symptoms
_____	_____	diminished sexual desire
_____	_____	excessive sexual desire
_____	_____	difficulty having an orgasm
_____	_____	difficulty achieving/holding pregnancy
_____	_____	number of pregnancies
_____	_____	number of miscarriages
_____	_____	number of terminations
_____	_____	number of live births

NOW	PAST	URINARY
_____	_____	difficulty urinating
_____	_____	frequent urging
_____	_____	frequent night urination
_____	_____	weak stream, difficulty starting stream
_____	_____	pain/burning when urinating
_____	_____	frequent bladder infections
_____	_____	kidney infection
_____	_____	kidney stones
_____	_____	lower back pain
_____	_____	discoloration of urine: red, brown, black

FAMILY HISTORY							
	Self	Mother	Father	Brother/s	Sister/s	Grandfather/s	Grandmother/s
Alcoholism/Addiction							
Allergies							
Anemia							
Arthritis							
Asthma							
Birth defects							
Bleeding d/o							
Cancer							
Diabetes/Hypoglycemia							
Eczema							
Epilepsy							
Gall bladder dz.							
Hay fever/Hives							
Heart dz./Hypertension							
Hepatitis							
Kidney dz.							
Mental Illness							
Migraines							
Tuberculosis							
Age at death							

DIETARY - INTAKE

Do you follow any dietary guidelines? (Vegetarian, Macrobiotic, etc) _____

Are there foods that you intentionally avoid?

_____

_____

_____

DAILY DIET SNAPSHOT		
Meal	**Typical Food**	**Typical Beverage**
Breakfast		
Mid-morning snack		
Lunch		
Mid-afternoon snack		
Dinner		
After dinner snack		
Late night snack		
Secret indulgence no-one else knows		

DIETARY - OUTPUT

Urination: # per day _____ Color _____ Pain with urination? Y N

Bowel movements # per day _____ Color _____ difficulty passing? Y N

Are your stools: Well formed Y N Loose Y N Constipated Y N Variable Y N Sink Float

Do you ever see in your stool: Blood Y N Mucus Y N Undigested food fibers Y N

OTHER HABITS				
Substance	**Current**	**Past**	**Never**	**Frequency**
Alcohol				
Coffee / tea / caffeine				
Refined sugar				
Tobacco				
Marijuana				
Other recreational drug use				

SOCIAL HISTORY & SELF-CARE HABITS

Y = yes N = no S = sometimes/somewhat

Do you have a supportive primary relationship? Y N S
Any history of physical mental or sexual abuse? Y N S
Any current abuse? Y N S
Do you have a supportive circle of friends? Y N S
Do you like your work? Y N S Hours of work/week _____
Do you watch television Y N S Hours of TV/week _____
Do you read books? Y N S Hours of reading/week _____
Do you exercise regularly? Y N S Hours of exercise/week _____
Do you sleep well? Y N S Hours of sleep/night _____
Do you have trouble falling asleep? Y N S Time to fall asleep _____
Do you have trouble with waking in the night? Y N S # times wake/night _____
Do you wake feeling rested? Y N S

What do you do for exercise/physical activity?

_____
_____
_____

What do you that brings you the most enjoyment?

_____
_____
_____

What do you think is causing your symptoms?

_____
_____
_____

How much change are you willing to make to resolve your health concerns?

MINIMAL SOME LOTS COMPLETE

Thank you for filling out this intake paperwork as completely as you can. It will help us to come to know you better, and to understand the context in which your health concerns arise. You may bring this with you to your first visit, or, if there is time, you may mail it to the address below so that we will have some time to carefully read it before we meet. We look forward to meeting with you.

Brian Paterson, ND, LAc and Kathryn Cranford, ND, NHCM

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