ADULT PATIENT PROFILE

Please complete the following questionnaire as thoroughly as possible. Please draw a line through or write "NA" in those sections, which do not apply. **PLEASE PRINT CLEARLY.** And, return by fax or mail to the office at least 72 hours before your first visit.

Last Name:	First Name:		Middle Initial
Date of Birth:	Age:	Gender: M or F	SS#:

Address (Street, city, zip)		
Home phone:	Cell phone:	
Employer:	Work Phone:	
Emergency Contact:	Phone:	Relation:
Email Address:	How did you hear about us? Name of person who referred.	

Present Health Concerns (in order of Importance)	Duration of concern

What level of change to your living habits are you willing to make to improve your health? check one):

☐ Whatever it takes ☐ Significant change ☐ Some change ☐ No change

Vitamins/Herbs/Supplements that you are now taking:

Name / type	Reason for taking	Dose/day (mg/etc)	For how long	Who prescribed

Drugs (prescription and over-the-counter, that you are now taking):

Allergies [drugs, food, environmental (grass/pollen, etc.) Please **circle** any, which are life-threatening]:				

MEDICAL HISTORY SECTION

Primary Care Doctor	Date Last seen:
Reason for Seeing this Doctor:	

Clinic Name:	Doctor Phone	Fax Number
Doctor's Full Address:		

Other Current Health Providers	**Type**	**Phone number**	**Fax number**

Please list below the answers to the following:	
Date of Last Full Physical Exam:	Results:
Date of Last Urine Test:	Results:
Date of Last Blood work:	Results overall:
(Males) Date of Last Prostate Exam:	Results:
(Females) Date of Last Pelvic Exam:	Results:
(Females) Date of Last Mammogram: DITI:	Results:
(Females) Are you Pregnant? YES NO	(Females) If so, how far along are you?
(Females) When was your last menstrual period?	(Females) How long are your menstrual cycles?
(Females) How many years have you been on birth control pills or hormone replacement therapy?	
How would you describe your general health?	

Outpatient Procedures / Hospitalizations (surgeries/ special diagnostic studies):

TYPE of Surgery / Study	**Date**	**Reason for procedure/admission**	**Outcome / Results**

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

TYPE	**Date**	**Treatment Received**	**Outcome / Results**

Family History

Using the following key, designate which family members have had the following. List type where parentheses are present.

M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

Condition	Who	Condition	Who	Condition	Who
Allergies		Diabetes		Kidney disease	
Alcoholism		Cancer ( )		Mental disorder ( )	
Anemia		Cancer ( )		Obesity	
Arthritis(Rheumatoid)		Epilepsy		Stroke	
Arthritis(Osteo)		Heart Disease		Thyroid (low/ high)	
Auto Immune disease		High Blood Pressure		Other: ( )	
Bleeding tendency		High Cholesterol		Other: ( )	

Social History (please check, or complete if applicable):

☐ Single ☐ Married ☐ Significant other Name of spouse/ partner:

Your Occupation? | Your Education?

If you have children, please list their names, ages, and health or wellness issues below.

Children Names	Age	Health / Wellness issues

Are you sexually active?	**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)?

Exercise (Complete this section only if you actually take time regularly to exercise)

TYPES of Exercise	How long per Session	Frequency	Practiced for how long

Check any of the following you do on a daily basis

☐Jog ☐ Swim ☐Walk ☐ Bicycle ☐Yoga ☐Breathing exercises ☐ Meditation
☐ Gardening ☐ Team Sports ☐ Other: (Please List)_____

Personal Care

☐ Oils ☐ Bath ☐ Sauna ☐ Tanning Devices ☐ Hair Spray☐ Cosmetics
☐ Steam Bath ☐ Electric Hair Dryer ☐ Other: (Please List):_____

Sleep Habits

How many hours a night?	Does sleep refresh you?	If not, Why?

What time do you usually go to sleep? | What time do you usually wake up?

Do you have problems: ☐ falling asleep ☐ staying asleep ☐ waking up in the morning

If you wake up during the night, how often and at what times does this happen?

Energy level: (average per week, circle one)

1 2 3 4 5 6 7 8 9 10
(lowest energy) (highest energy)

Stress Level: (average per week, circle one)

1 2 3 4 5 6 7 8 9 10

(lowest energy) (highest energy)

How do you cope with stress?

Who do you talk to about your problems?

Who else might you confide in or seek advice from?

What do you do for fun and how often?

TOXIC Exposures

Are you sensitive to chemical smells?

List any chemicals, fumes, and dusts etc. that you are or have been repeatedly exposed to:

Are you exposed to any chemicals, solvents, paints, etc. in your work or home environment?

Please specify which ones:

Food Preparation Equipment (Please check all that apply)

☐ Blender ☐ Wok ☐ Pressure Cooker ☐ Electric Stove ☐ Gas Stove

☐ Toaster oven ☐ Juicer ☐ Microwave ☐ Aluminum Cookware

Diet History (include any liquid tea, coffee, etc., in description below).

What is the percentage of raw food in your diet?

What is the percentage of cooked food in your diet?

Who cooks the meals in your household?

Do you have any food allergies?

What did you eat for breakfast yesterday?

What did you eat for lunch yesterday?

What did you eat for dinner yesterday?

List the snacks that had yesterday:

How many glasses of **plain water** do you drink per day?_____

Was it: ☐Filtered ☐Ttap ☐Distilled ☐Well water ☐Alkaline

Do you practice any special diet restrictions?

Personal Habits (Check or describe in the following boxes).

	Tobacco	**Alcohol**	**Caffeine**	**Recreational Drugs**
Currently Use:				
Previously Used:				
Never Used:				
How much/many: (per day/week/ month/ etc.)				
Specify type: (filtered/not; beer/ wine/mixed drinks; tea/coffee/espresso				
For how long (months/years)				
Date quit				

Eliminations (Please complete):			
Bowel Habits		**Urination Habits**	
Frequency: (how often) Twice/ day, every week…		**Frequency: (how often per 24hour period)**	
Color: (black, brown, yellow, green, white)		**Color: (dark yellow, light yellow, green, colorless)**	
Consistency: (hard, formed, soft, watery)		**Character: (clear, cloudy, concentrated, dilute)**	
Any mucus or blood on stool? (which)		**Any blood or sediment? (which)**	
Does stool pass easily?		**Any pain, incontinence, other urinary symptoms?**	

Digestion
Do you experience any stomach upset or heartburn?
Do you experience any bloating associated with foods?
Do you experience any burping?
Do you experience any flatulence (gas)?
Do you experience any nausea around meal time?
Do you experience any rectal itching after meals?
How many courses of antibiotics have you taken in the last 3 years, if any?

REVIEW OF SYSTEMS: (Circle, ✓ if you **now have**, <u>or</u> **Circle 'P'** in space, if you **previously have had** any of the following). List type where appropriate:

Anemia	✓ or P	Asthma	✓ or P	Kidney Failure	✓ or P
Blood Disease	✓ or P	Blood Disease	✓ or P	Kidney Infection	✓ or P
Fatigue (Affecting daily living)	✓ or P	Bronchitis	✓ or P	Kidney Stones	✓ or P
Dizziness (more than 5 seconds)	✓ or P	Tuberculosis	✓ or P	Sexually Transmitted Disease	✓ or P
Recurrent Headaches	✓ or P	Stomach Ulcers	✓ or P	Thyroid Problems:_____	✓ or P
Loss of Hearing	✓ or P	Constipation	✓ or P	Diabetes	✓ or P
Ringing in the ears (more than 5 sec.)	✓ or P	Diarrhea (infectious)	✓ or P	Significant swelling of ankles	✓ or P
Recent loss or change in vision	✓ or P	Diarrhea (bloody)	✓ or P	Liver disease	✓ or P
Eye pain	✓ or P	Lasting nausea	✓ or P	Hepatitis	✓ or P
Frequent sore throats	✓ or P	Recurrent vomiting	✓ or P	Arthritis _____	✓ or P
Persistent numbness	✓ or P	Chest pain	✓ or P	Persistent neck pain/stiffness	✓ or P
Persistent weakness	✓ or P	Heart disease	✓ or P	Persistent low back pain/stiff	✓ or P
Persistent tingling	✓ or P	Heart failure	✓ or P	Bursitis	✓ or P
Nervousness /Depression	✓ or P	Irregular heart beat	✓ or P	Hot and swollen joints	✓ or P
Skin problems	✓ or P	Hemorrhoids	✓ or P	Prostate enlargement	✓ or P
Brittle nails	✓ or P	Unusually severe bruising	✓ or P	Female cramps	✓ or P
Recent hair loss	✓ or P	Frequent nose bleeds	✓ or P	Excessive Menstrual Flow	✓ or P
Allergies	✓ or P	Varicose veins	✓ or P	Hot flashes	✓ or P
Frequent sinus infections	✓ or P	Poor circulation	✓ or P	Irregular menstrual cycles	✓ or P
Cancer	✓ or P	Stroke	✓ or P	Fibrocystic breasts	✓ or P
Other:		Other:		Other:	

Anything else we need to know about you?

- **Please complete this Adult Patient Profile along with the Metabolic Assessment Questionnaire, Director of Clinic and Cancellation Policy and return by fax or email. Forms MUST be completed and sent in prior to setting your New Patient visit.**

- **Please, fax or email copies of bloodwork labs along with this Adult Patient Profile. Bring any diagnostic and/or imaging reports to the New Patient visit if possible. If mailing forms/labs/reports, please retain a copy for your records.**

At Holistic Options we would like to provide you and your family with quality healthcare.