Springs Natural Medicine 1010 W Colorado Ave Ste D, Colorado Springs, CO 80904 719-685-2500

Adult Patient Profile:

Please complete the following questionnaire as thoroughly as possible to help our doctors understand who you are on a physical, emotional, mental and spiritual level. Our doctors believes that the person you are today is a result of everything that has happened to you throughout your lifetime starting from the moment of birth. This will become a part of your confidential records and will not be released unless you have authorized us to do so.

Last name:_____First Name:_____Middle initial:_____

Date of birth:_____Age:_____Gender (sex):_____Email*: _____

Address:_____City:_____State:____Zip:_____

Home Phone: (___)_____Work Phone:(___)_____

Emergency contact:_____Phone:(___)_____Relation:_____

How did you hear about us?_____

Could we send them a thank you card? yes no Please sign for your consent:_____

*Email will only be used to contact you or to send you our bimonthly month newsletter and will not be shared with anyone.

We send out newsletters every two months, would you like to receive it by email or USPS (please circle)

Present Health Concerns (in order of importance): Duration:

1_____

2_____

3_____

Please describe what you think is the cause of your health conditions (you can use the back of the page if needed):

_____

_____

_____

_____

_____

Vitamins/Herbs/Supplements that you are 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):

Name of drug	Reason for drug	Dose (mg/etc)	For how long	Prescribing doctor

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

Are you sensitive to chemical smells?_____ List any chemicals, fumes, and dusts etc. that you are or have been repeatedly exposed to:

Medical/Health History:

Primary Care Doctor/Provider (if any):_____Date last seen:_____

Reason for seeing:_____

Doctor's phone:(___)_____Fax:(___)_____

Doctor's full address:_____

Other Current Health Provider(s):

Type:	Phone:	Fax:
1._____	(___)_____	(___)_____
2._____	(___)_____	(___)_____
3_____	(___)_____	(___)_____

Date of last full physical exam:_____Results:_____ Date of last urine test: _____Results:_____

Date of last blood work:_____ Results: _____

Date of last PAP/ pelvic exam (females):_____Results:_____

Date of last mammogram (females over 40):_____ Findings:_____

Date of last prostate exam (males):_____Results:_____

Are you Pregnant?_____If so, how far along?_____When was your last menstrual period?_____

How long are your cycles?_____ Cramping or pain during your period?_____

Any PMS symptoms?(bloating, irritability, mood swings, cravings)_____

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

Single Married Significant other Name of spouse/ partner:_____

Your Occupation:_____ Your Education:_____

Children (names/ ages and health or wellness issues):_____
_____

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)?_____

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)	
Autoimmune Disease		High Blood Pressure		Other	
Bleeding Tendency		High Cholesterol		Other	

Exercise:

Type(s) How long per session Frequency Practiced for how long?
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Sleep Habits:

How many hours/night:_____Do you wake refreshed?_____If not why?_____

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

Energy level (average per week, circle one):

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

Stress level (average per week, circle one):

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

How do you cope with stress?_____

Who do you talk to about your problems?_____

What do for fun and how often?_____

Diet history (include any liquid tea, coffee, etc., in description):
What was breakfast yesterday?_____
What was lunch yesterday?_____
What was dinner yesterday?_____
List snacks you had yesterday:_____

How many glasses of **plain water** do you drink per day?_____ filtered tap distilled well water
Do you practice any special diet restrictions?_____

Personal Habits (check or describe usage)

	Tobacco	Alcohol	Caffeine	Recreational drugs
Currently use:	_____	_____	_____	_____
Previously used:	_____	_____	_____	_____
How much/many:	_____	_____	_____	_____
Specify type:	_____	_____	_____	_____
Date quit:	_____	_____	_____	_____

Eliminations (please complete):

Bowel Movement habits
Frequency: (how often)_____Consistency: (hard, formed, soft, watery)_____
Color: (black, brown, yellow, green, white)_____ Any mucus or blood on stool?(which)_____
Does stool pass easily? _____

Urine habits
Frequency: (how often per 24hour period)_____Character: (clear, cloudy, concentrated, dilute)_____
Color: (dark yellow, light yellow, green, colorless)_____ Any blood or sediment? (which)_____
Any pain, incontinence, other urinary symptoms?_____

Digestion: Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food? (circle or specify):_____

Review of Systems (check if you **now** have, or circle if you **previously have had** any of the following. List type where appropriate)

☐ anemia
☐ blood diseases
☐ fatigue (affecting daily living)
☐ dizziness (more than 5 seconds)
☐ recurrent headaches
☐ loss of hearing
☐ ringing in ears
☐ recent loss or change in vision
☐ eye pain
☐ frequent sore throat
☐ persistent numbness or weakness
☐ nervousness/depression
☐ skin problems ( )
☐ brittle nails
☐ recent hair loss
☐ allergies
☐ frequent sinus infections
☐ cancer( )
☐ asthma ☐difficulty breathing
☐ chronic bronchitis
☐ tuberculosis
☐ stomach ulcers
☐ constipation
☐ diarrhea
☐ lasting nausea
☐ recurrent vomiting
☐ chest pain
☐ heart disease
☐ heart failure
☐ irregular heart beat
☐ hemorrhoids
☐ unusually severe bruising
☐ frequent nose bleeds
☐ varicose veins
☐ poor circulation
☐ stroke
☐ kidney failure
☐ kidney stones
☐ kidney infection
☐ sexually transmitted diseases
☐ thyroid problems
☐ diabetes
☐ significant swelling of ankles
☐ liver disease

☐ hepatitis
☐ arthritis
☐ persistent neck pain / stiffness ☐ persistent low back pain / stiffness
☐ bursitis
☐ hot and swollen joints
☐ prostate enlargement
☐ female cramps
☐ excessive menstrual flow
☐ hot flashes
☐ irregular menstrual cycles ☐fibrocystic breasts
☐ other ( )
☐ other ( )