Natural Health Medical Clinic – Dr. Ruhland 206-723-4891

CONFIDENTIAL PATIENT INFORMATION

Today's date ____________, 2017

Name _______________________________ Birth date ____________ Age _____ Sex (circle): M F

Home phone ________________ Cell ________________ Email ________________________________

Street _______________________________________ City ________________ State ___ Zip ________

Employment (circle): Full-time Part-time Retired Student Social Security _______________

Occupation___________________________ Employer________________ Work Phone ____________

Driver's License #___________________ Emergency Notification Person _______________________

Relationship to you _________ their Phone ______________ Address __________________________

Is condition related to (circle): Employment Auto Accident Accident Date ______________

Lost any days from work? (circle): Yes No On Disability (circle): Yes No

How did you learn about our clinic, or who referred you?_________________________________

MAJOR CONCERNS

What are your main health concerns? How long you have had them, or the reason for appointment:

____

Major stressors just prior to symptoms ____

Have you ever had the same or similar conditions? (circle): Yes No First onset ______________

Names of recent doctors consulted _________________________________ Dates__________________

Date of last thorough checkup _____________ What do you believe is wrong? ___________________

____

PAST MEDICAL HISTORY

Serious Illnesses ____

Surgeries ____

Major accidents ____

Hospitalizations ____

Mental / Emotional Illness ___________________________ How many close friends have you? ____

Medications & Supplements ____

Allergies: Medications, Inhalants, Foods ____

Major Childhood Illnesses ____

Chemicals, fumes, dusts, pets, radiation, etc. to which you are repeatedly exposed

____

Immunizations _____________________ Describe scars you have _______________________________

How many hours do you sleep at night? _____ How often do you awaken refreshed?___________

How many glasses of water do you drink daily? _____ Is this enough for you? _____________

What is your energy on a scale of 1-10? (1 = lowest, 10 = the most energy imaginable) _____

Are you seeking a specific therapy? ____

For Dr. Ruhland to fill out			
Height	Weight	BP	Pulse

Circle medications you currently take:

- Antacids
- Antibiotics/Antifungals
- Antidepressants
- Antidiabetics/Insulin
- Aspirin/Tylenol
- AntiHypertensives
- Chemotherapy
- Cholesterol
- Cortisone/ Anti-inflammatories
- Decongestants
- Diuretics
- Hormones
- Laxatives
- Oral Contraceptives
- Radiation
- Relaxants
- Sleeping Pills
- Recreational Drugs
- Thyroid _______________
- Ulcer Medications
- Other _________________ _________________________

I eat, drink or use (circle):

- Alcohol
- Candy
- Carbonated Beverages
- Cigarettes
- Coffee
- Filtered Water
- Fluoridated Water
- Chlorinated Water
- Regularly Eat at Fast Food Restaurants
- Fried Foods
- Refined (White) Flour Products
- Dairy Products
- Luncheon Meats
- Margarine
- Sugars
- Artificial Sweeteners
- Non Herbal Teas
- Vitamins and Minerals Specify: ___________________
- Special Diet (be specific) ________________________ ________________________

Do you? (circle):

- Diet often
- Have much stress
- Salt food without tasting
- Exercise less than 3 times weekly
- Think you are or have been exposed to toxins
- Think you need help with your diet

I am (circle):

- Warmer than others
- Chillier than others

FAMILY HISTORY

Identify any family members who have had any of the following:

Abbreviations: Self (S) Mother (M) Father (F) Brother (B) Sister (S) Grandparent (G) Your Children (C)

	Self	M	F	B	S	G	C
Smoking	□	□	□	□	□	□	□
Alcoholism	□	□	□	□	□	□	□
Allergies	□	□	□	□	□	□	□
Anemia	□	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□
Birth Defects	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□
Ear Infections	□	□	□	□	□	□	□
Epilepsy/Seizures	□	□	□	□	□	□	□
Hearing Loss	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□

	Self	M	F	B	S	G	C
High Blood Pressure	□	□	□	□	□	□	□
Hypoglycemia	□	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□	□
Memory Loss	□	□	□	□	□	□	□
Mental Illness	□	□	□	□	□	□	□
Pneumonia	□	□	□	□	□	□	□
Strep Throat	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□
Thyroid Disorder	□	□	□	□	□	□	□
Tuberculosis	□	□	□	□	□	□	□
Other_______________	□	□	□	□	□	□	□
Other_______________	□	□	□	□	□	□	□

Age and cause of parents' death: ____

MENTAL / EMOTIONAL HEALTH HISTORY

What do you consider strong points in your health or life? ________________________________

____

What is a typical day like for you? ____

____

Relationship History: (circle) Single Partner Widowed Years in longest relationship _____
No. of Children ___ Ages of children ________________________
Is there anyone you are afraid of? __________________________________
Do you use a contraceptive? (circle): Yes No What type? ____________________________
First day of last menstrual period _______ Last Pap Test: ______
Are you pregnant? (circle): Yes No Not Sure
What are your main stressors? ____

REVIEW OF SYSTEMS

Please CHECK the items from which you have suffered:

□ Food Allergies	□ Foot Trouble	□ Ear Noises	□ Bed-wetting
□ Hay Fever	□ Low Back Pain	□ Deafness	□ Frequent Urination
□ Difficult Breathing	□ Neck Pain or Stiffness	□ Enlarged Thyroid	□ Kidney Infections or Stones
□ Asthma	□ Poor Posture	□ Failing Vision	□ STD's
□ Pleurisy	□ Sciatica	□ Bruise Easily	□ Prostate Problems
□ Frequent Colds	□ Scoliosis	□ Nosebleeds	□ Cramps or Backache
□ Sinus Infections	□ Swollen Joints	□ Varicose Veins	□ Excessive menstrual Flow
□ Dizziness	□ Colon Trouble	□ Low BP	□ Hot Flashes
□ Fatigue	□ Gas / Bloating	□ Heart Pain	□ Irregular Cycle
□ Headaches	□ Constipation / Diarrhea	□ Chest Pain	□ Breast Lumps
□ Insomnia	□ Difficult Digestion	□ Poor Circulation	□ Yeast / Candida Infection
□ Anxiety	□ Hemorrhoids	□ Rapid Heart-rate	□ Acne / Eczema
□ Depression	□ Ulcers	□ Heart Murmur	□ Mercury Fillings (how many?) __
□ Head Injury	□ Nausea	□ Irregular Heart-rate	□ Root Canals (how many?) ____
□ Learning Disorder	□ Vomiting Spells	□ Slow Heart-rate	
□ Numbness	□ Jaundice	□ Swollen Ankles	

Of those checked conditions above, please CIRCLE those from which you currently suffer.

I currently have tingling or numbness in:

□ Shoulders □ Elbows □ Arms □ Hands □ Fingers □ Hips □ Knees □ Legs □ Feet □ Toes

Do you have any other problems you would like to discuss?

____

____

If you could, would you be willing to improve your health by making simple changes in living habits? (circle): Yes No

If there is one main health concern we could help you with today, what should it be?

____

____