Holly Zapf, ND -- Whole Family Health Clinic

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Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home): _____ (work): _____

E-mail address: _____

Age: _____ Date of Birth: _____ Gender: female ____ male ____

Education: _____

Married: ___ Separated: ____ Divorced: ___ Widowed: ___ Single: ___ Partnership: ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ____

Occupation: _____ Hours per week: ___ Retired: ___

Employer: _____ SS#: _____

(Work address): _____

How did you hear about our clinic? _____

_____

Has any other family member already been a patient at the clinic? _____

_____

Next of Kin or other to reach in an emergency: _____

Relationship: _____ Phone: _____

Address: _____

_____

PLEASE FILL OUT BOTH SIDES

Are you currently receiving healthcare elsewhere? Y N

If yes, where and from whom: _____

_____

If no, when and where did you last receive medical or health care? _____

_____

What was the reason?

_____

What are your most important health problems? List as many as you can in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Family History

	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILD
Age (if living)						
Health (G=good P=poor						
Age at death (if deceased)						
Check (X) those applicable						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness / Depression						
Asthma / Hay fever / Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Cause of Death						
Alcoholism						

Any other relevant family history? _____

_____

_____

What is your heritage (ethnicity)?

_____

Childhood Illnesses

Please circle whether you had any of these as a child:

Scarlet fever	Diphtheria	Rheumatic fever
Mumps	Measles	German measles

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-rays, CAT Scans, EEGs, EKG's have you had:

_____year: _____year: _____year:

_____year: _____year: _____year:

_____year: _____year: _____year:

Allergies

Are you hypersensitive or allergic to…

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

Current Medications

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Antibiotics	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N	Sleeping pills	Y	N

Please list **any** prescription medication, over the counter medications, vitamins or other supplements you are taking?

1) _____ 7) _____

2) _____ 8) _____

3) _____ 9) _____

4) _____ 10) _____

5) _____ 11) _____

6) _____ 12) _____

General

Height: _____ Weight: _____lbs. Weight 1 year ago: _____lbs.

Maximum Weight: _____ When: _____

When during the day is your energy best? _____ worst? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you have now N = never had P = significant problems in the past

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y	N	P	___	Depression?	Y	N	P	___
Mood swings?	Y	N	P	___	Anxiety or nervousness?	Y	N	P	___
Considered/attempted suicide?	Y	N	P	___	Tension?	Y	N	P	___
Poor concentration?	Y	N	P	___	Memory problems?	Y	N	P	___

Immune

Reactions to immunizations?	Y	N	P	___	Reactions to vaccinations?	Y	N	P	___
Chronic Fatigue Syndrome?	Y	N	P	___	Tension?	Y	N	P	___
Chronically swollen glands?	Y	N	P	___	Slow wound healing?	Y	N	P	___

Endocrine

Hypothyroid?	Y	N	P	___	Heat or cold intolerance?	Y	N	P	___
Hypoglycemia?	Y	N	P	___	Diabetes?	Y	N	P	___
Excessive thirst?	Y	N	P	___	Excessive hunger?	Y	N	P	___
Fatigue?	Y	N	P	___	Seasonal depression?	Y	N	P	___

Neurologic

Seizures?	Y	N	P	___	Paralysis?	Y	N	P	___
Muscle weakness?	Y	N	P	___	Numbness or tingling?	Y	N	P	___
Loss of memory?	Y	N	P	___	Easily stressed?	Y	N	P	___
Vertigo or dizziness?	Y	N	P	___	Loss of balance?	Y	N	P	___

Skin

Rashes?	Y	N	P	___	Eczema, Hives?	Y	N	P	___
Acne, Boils?	Y	N	P	___	Itching?	Y	N	P	___
Color changes?	Y	N	P	___	Perpetual hair loss?	Y	N	P	___
Lumps?	Y	N	P	___	Night sweats?	Y	N	P	___

Head

Headaches?	Y	N	P	___	Head injury?	Y	N	P	___
Migraines?	Y	N	P	___	Jaw / TMJ problems?	Y	N	P	___

Eyes

Spots in eyes?	Y	N	P	___	Cataracts?	Y	N	P	___
Impaired vision?	Y	N	P	___	Glasses or contacts?	Y	N	P	___
Blurriness?	Y	N	P	___	Eye pain / strain?	Y	N	P	___
Color blindness?	Y	N	P	___	Tearing or dryness?	Y	N	P	___
Double vision?	Y	N	P	___	Glaucoma?	Y	N	P	___

Ears

Impaired hearing?	Y	N	P	___	Ringing?	Y	N	P	___
Earaches?	Y	N	P	___	Dizziness?	Y	N	P	___

Nose and Sinuses

Frequent colds?	Y	N	P	___	Nose bleeds?	Y	N	P	___
Stuffiness?	Y	N	P	___	Hay fever?	Y	N	P	___
Sinus problems?	Y	N	P	___	Loss of smell?	Y	N	P	___

Mouth and Throat

Frequent soar throat?	Y	N	P	___	Copious saliva?	Y	N	P	___
Teeth grinding?	Y	N	P	___	Sore tongue / lips?	Y	N	P	___
Gum problems?	Y	N	P	___	Hoarseness?	Y	N	P	___
Dental cavities?	Y	N	P	___	Jaw clicks?	Y	N	P	___

Neck

Lumps?	Y	N	P	___	Swollen glands?	Y	N	P	___
Goiter?	Y	N	P	___	Pain or stiffness?	Y	N	P	___

Respiratory

Cough?	Y	N	P	___	Sputum?	Y	N	P	___
Spitting up blood?	Y	N	P	___	Wheezing?	Y	N	P	___
Asthma?	Y	N	P	___	Bronchitis?	Y	N	P	___
Pneumonia	Y	N	P	___	Pleurisy?	Y	N	P	___
Emphysema?	Y	N	P	___	Difficulty breathing?	Y	N	P	___
Pain on breathing?	Y	N	P	___	Shortness of breath?	Y	N	P	___
Shortness of breath at night?	Y	N	P	___	Shortness of breath lying down?	Y	N	P	___
Tuberculosis?	Y	N	P	___					

Cardiovascular

Heart disease?	Y	N	P	___	Angina?	Y	N	P	___
High/low blood pressure?	Y	N	P	___	Murmurs?	Y	N	P	___
Blood clots?	Y	N	P	___	Fainting?	Y	N	P	___
Phlebitis?	Y	N	P	___	Palpitations/fluttering?	Y	N	P	___
Rheumatic fever?	Y	N	P	___	Chest pain?	Y	N	P	___
Swelling in ankles?	Y	N	P	___					

Gastrointestinal

Trouble swallowing?	Y	N	P	___	Heartburn?	Y	N	P	___
Change in thirst?	Y	N	P	___	Abdominal pain / cramps?	Y	N	P	___
Change in appetite?	Y	N	P	___	Belching or passing gas?	Y	N	P	___
Nausea / vomiting?	Y	N	P	___	Constipation?	Y	N	P	___
Ulcer?	Y	N	P	___	Diarrhea?	Y	N	P	___
Jaundice (yellow skin)?	Y	N	P	___	Bowel movements: How often?				_____
Gall bladder disease?	Y	N	P	___	Is this a change?				_____

Liver disease?	Y	N	P	___	Black stools?	Y	N	P	___
Hemorrhoids?	Y	N	P	___	Blood in stools?	Y	N	P	___

Urinary

Pain on urination?	Y	N	P	___	Increased frequency?	Y	N	P	___
Frequency at night?	Y	N	P	___	Inability to hold urine?	Y	N	P	___
Frequent infections?	Y	N	P	___	Kidney stones?	Y	N	P	___

Musculoskeletal

Joint pain or stiffness?	Y	N	P	___	Arthritis?	Y	N	P	___
Broken bones?	Y	N	P	___	Weakness?	Y	N	P	___
Muscle spasms or cramps?	Y	N	P	___	Sciatica?	Y	N	P	___

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y	N	P	___	Anemia?	Y	N	P	___
Deep leg pain?	Y	N	P	___	Cold hands / feet?	Y	N	P	___
Varicose veins?	Y	N	P	___	Thrombophlebitis?	Y	N	P	___

Male Reproduction

Hernias?	Y	N	P	___	Testicular masses?	Y	N	P	___
Testicular pain?	Y	N	P	___	Prostate disease?	Y	N	P	___
Venereal disease?	Y	N	P	___	Discharge or sores?	Y	N	P	___
Are you sexually active?	Y	N			Chlamydia	Y	N	P	___
Sexual orientation: _____					Gonorrhea?	Y	N	P	___
Impotence?	Y	N	P	___	Condyloma?	Y	N	P	___
Premature ejaculation?	Y	N	P	___	Herpes?	Y	N	P	___
Birth control? Type? _____					Syphilis?	Y	N	P	___

Female Reproduction / Breasts

Age of first menses? _____					Date of last annual exam / PAP: _____				
Age of last menses? (if menopausal) _____					Are cycles regular?	Y	N	P	___
Length of cycle? _____ days					Bleeding between cycles?	Y	N	P	___
Duration of menses? _____ days					Pain during intercourse?	Y	N	P	___
Painful menses?	Y	N	P	___	Clotting?	Y	N	P	___
Heavy or excessive flow?	Y	N	P	___	Discharge?	Y	N	P	___
PMS?	Y	N	P	___	Birth Control?	Y	N	P	___
If yes, what are you symptoms?					What type? _____				
_____					Number of pregnancies: _____				
_____					Number of live births: _____				
Endometriosis?	Y	N	P	___	Number of miscarriages: _____				
Ovarian cysts?	Y	N	P	___	Number of abortions: _____				
Difficulty conceiving?	Y	N	P	___	Menopausal symptoms?	Y	N	P	___
Cervical Dysplasia?	Y	N	P	___	Abnormal PAP?	Y	N	P	___
Sexual difficulties?	Y	N	P	___	Chlamydia?	Y	N	P	___
Gonorrhea?	Y	N	P	___	Condyloma?	Y	N	P	___
Herpes?	Y	N	P	___	Syphilis?	Y	N	P	___
Are you sexually active?	Y	N			Sexual orientation: _____				
Do you do breast self-exams?	Y	N	P	___	Breast lumps?	Y	N	P	___
Breast pain / tenderness	Y	N	P	___	Nipple discharge?	Y	N	P	___

Habits

Main interests and hobbies? _____

Do you exercise? Y N

If yes, what kind? _____ How often? _____

Average 6-8 hrs. sleep?	Y	N		Enjoy your work?	Y	N	
Sleep well?	Y	N		Take vacations?	Y	N	
Awaken rested?	Y	N		Spend time outside?	Y	N	
Have a supportive relationship?	Y	N		Watch television	Y	N	
Have a history of abuse?	Y	N		how many hours?			
Any major traumas?	Y	N	P	Read?	Y	N	
Use recreational drugs?	Y	N	P	how many hours?			
Been treated for drug dependency?	Y	N	P	Do you eat 3 meals a day?	Y	N	
Use alcoholic beverages?	Y	N	P	Do you go on diets often?	Y	N	
Treated for alcoholism?	Y	N	P	Do you drink coffee?	Y	N	P
Do you use tobacco?	Y	N	P	Drink black/green tea?	Y	N	P
Smoke previously?	Y	N	P	Do you drink cola/other sodas?	Y	N	P
How many years? _____				Do you eat refined sugar?	Y	N	P
How many packs per day? _____				Do you add salt?	Y	N	P

Do you have a religious or spiritual practice? Y N

If yes, what? _____

Is there anything else you would like to add or comment on?

How does your condition affect you? _____

_____

_____

What do you think is happening? _____

_____

_____

Why? _____

_____

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 to 10 being 100% committed.)

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

What behaviors of lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you feel needs to happen for you to get better? _____

_____

What do you enjoy most in your life? _____

_____