

Kelley R. Reis

Naturopathic Physician

503-693-0904

The Natural Medicine Center

172 SE 6th Ave

Hillsboro, OR 97123

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: _____ S.S.#: _____

(Work address): _____

How did you hear about Dr. Reis? _____

Has any other family member already been a patient of Dr. Reis? _____

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

Relationship: _____ Phone: _____

Address: _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to see Dr. Reis?

- What do you know about her approach?

2) What three expectations do you have from this visit?

- What long term expectations do you have of me personally as your physician?

3) 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, with 10 being 100% committed)

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

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

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

5) 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?

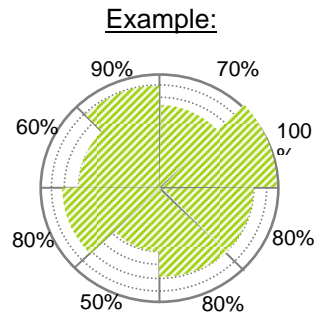
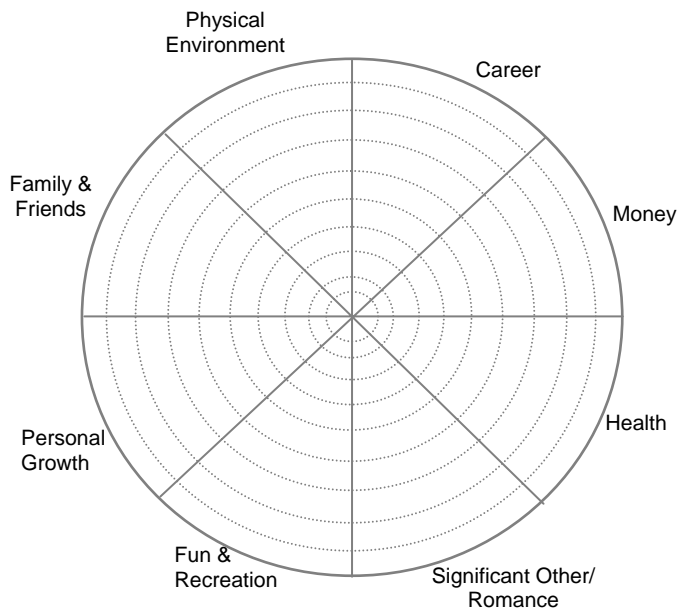
6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Are you currently receiving healthcare? 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) _____

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

Family History

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hayfever/Hives			

Any other relevant family history? _____

What is your heritage: German _____ Nordic _____ Celtic _____ Other _____

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, EEG, EKG's have you had?

_____ 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 medications, over the counter medications, vitamins or other supplements you are taking?

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

General

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

Maximum Weight : _____ When: _____

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

Y=a condition you have now**N**=Never had**P**=Significant problem in the past**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 Change?	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	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore 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

Y=a condition you have now**N**=Never had**P**=Significant problem in the past**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	“ “ “ 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 or 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 stool?	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

Y=a condition you have now

N=Never had

P=Significant problem in the past

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
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 your symptoms? _____		What type? _____	
_____		Number of pregnancies: _____	
Endometriosis?	Y N P	Number of live births: _____	
Ovarian cysts?	Y N P	Number of miscarriages: _____	
Difficulty conceiving?	Y N P	Number of abortions: _____	
Cervical Dysplasia?	Y N P	Menopausal symptoms?	Y N P
Sexual difficulties?	Y N P	Abnormal PAP?	Y N P
Gonorrhea?	Y N P	Chlamydia?	Y N P
Herpes?	Y N P	Condyloma?	Y N P
Are you sexually active?	Y N	Syphilis?	Y N P
Do you do breast self exams?	Y N P	Sexual orientation: _____	
Breast pain/tenderness?	Y N P	Breast lumps?	Y N P
		Nipple discharge?	Y N P

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

Thank you for your time and effort. I look forward to providing you with the best possible care.

The Natural Medicine Center

503-693-0904
172 SE 6th Ave.
Hillsboro, OR 97123

Dear New Patient,

Welcome to our clinic. We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care.

Initials **Payment for all services and dispensary items is due at the time of the visit.**

Initials **We are not providers on all insurance plans, therefore you may be required to bill your own insurance. We will provide you with all the necessary information for you to send your claim for reimbursement. You have the primary relationship with your insurance company and are responsible for the entire amount that is owed.**

Initials **You will be charged a Missed Appointment fee for any missed appointments or late cancellations (less than 24 hours notice).**

Initials **I give permission for the staff at The Natural Medicine Center to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.**

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of \$25.00 for every returned check(s). We can arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care providers who may be providing similar services at The Natural Medicine Center. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at The Natural Medicine Center.

Your health care provider may prescribe medication, which may be purchased either at The Natural Medicine Center or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Your Signature (parent signature if minor)

Print your name (parent name if minor & patient name)

Date