KRISTINE TROCKELS ND

# CONFIDENTIAL PATIENT INFORMATION

| Name | DOB | Gender ☐ M ☐ F |
|---|---|---|
| | Email | |

| Address | Home Phone |
|---|---|
| | Mobile Phone |
| | Best way to communicate with you? _____ |

**EMERGENCY INFORMATION**

Name: _____Relationship: _____Phone:_____

Have you seen a doctor that practices natural or integrative medicine before? ☐ Yes ☐ No

If so what type: ❑ Holistic MD/DO □ Naturopathic Doctor □ Acupuncturist □ Chiropractor □ Other: ____

How did you find us? ☐ Doctor Referral ☐ Patient Referral ☐ Web Search ☐ Other

If you were referred, please let us know by whom: _____

Do you have questions about Naturopathic Medicine?

What are your health goals?

What behaviors are in the way of achieving optimal health?

What things do you do that support good health?

How committed are you to making changes in your diet and lifestyle?

Do you have health insurance? ☐ Yes ☐ No If Yes ☐ HMO ☐ PPO

Who is your insurance carrier?_____

**HEALTH CARE PROVIDERS –** Please list other providers you are currently working with

| Name | Specialty | Contact Information |
|---|---|---|
| | | |
| | | |
| | | |

**CURRENT HEALTH CONCERNS**

| List by order of importance (Attach another list if necessary) | How long has this been a problem? | Sought diagnosis or treatment for this before? If so, please describe |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

**PAST MEDICAL HISTORY**

| | |
|---|---|
| Were you born C-section? | ☐ Yes ☐ No |
| Were you fully vaccinated? | ☐ Yes ☐ No |
| Do you get a flu shot annually? | ☐ Yes ☐ No |
| Any personal history of | |
| Cancer | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No |
| Heart Disease | ☐ Yes ☐ No |
| Respiratory illness | ☐ Yes ☐ No |
| Autoimmune diagnosis | ☐ Yes ☐ No Specify:_____ |

List any childhood illnesses:

List any surgeries or hospitalizations:

**LIST PRESCRIPTION MEDICINES -** Add additional sheet if necessary.

| Medication | Dose | When Started | Why Taking | Who prescribed |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**LIST ANY SUPPLEMENTS, BOTANICALS, HOMEOPATHY, ETC. -** Add additional sheet if necessary.

| Product | Dose | When Started | Why Taking | Who prescribed |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**LIST ANY ALLERGIES -** Add additional sheet if necessary.

| Drugs | Foods | Environmental |
|---|---|---|
| | | |

**FAMILY HISTORY**

| Member | Living | Overall Health | Age | Deceased/Cause |
|---|---|---|---|---|
| Mother | ☐ | | | ☐ _____ |
| Father | ☐ | | | ☐ _____ |
| Grand Parents | | | | |
| Mother's Mom | ☐ | | | ☐ _____ |
| Mother's Dad | ☐ | | | ☐ _____ |
| Father's Mom | ☐ | | | ☐ _____ |
| Father's Dad | ☐ | | | ☐ _____ |
| Siblings | ☐ | How many _____ Gender/Age M_____/_____ F_____/_____<br>Overall health _____<br>If deceased, please state cause _____ | | |
| Children | ☐ | How many _____ Gender/Age M_____/_____ F_____/_____<br>Overall health _____<br>If deceased, please state cause _____ | | |

**SOCIAL HISTORY**

**Exercise**

How many days per week? _____
How long per session? _____
Do you feel tired afterwards or energized? □ Tired □ Energized
Do you have a gym membership? □ Yes □ No
List types of exercise you do? _____
Rate your energy level on scale of 1-10 (10 is best): _____
Best time of day for energy _____ Worst time of day for energy: _____

**Employment**

What is your occupation? _____
How many hours per day? _____
Days per week?_____
Do you enjoy your job? _____
Do you have any chemical or other exposures at work? _____

**Stress**

Rate your stress on a scale of 1-10 (10 is highest)? _____
How do you cope with Stress? _____
What are the sources of your stress? _____

| **Home Situation** | ❑ Married ❑ Single ❑ Widowed ❑ Divorced |
|---|---|
| Are you happy with your status? | ❑ Yes ❑ No |
| Do you have any pets? | ❑ Yes ❑ No |
| Do your pets sleep in your bed? | ❑ Yes ❑ No |
| Who lives in your home? | _____ |

**Habits**

Have you ever smoked cigarettes? ❑ Yes ❑ No How many_____ How long? _____
Do you drink alcohol? ❑ Yes ❑ No What kinds? _____ How often? _____ How much? _____
Have you ever used recreational drugs? ❑ Yes ❑ No Types? _____ Current use? ____
Ever been a victim of abuse? ❑ Yes ❑ No ❑ Physical ❑ Emotional ❑ Sexual

**Emotional History**

Describe your current mental disposition (worrier, fearful, depressed, etc.)

_____
Any religious or spiritual practice? _____

**Diet**

Are there any foods that you crave strongly? _____
What foods make you feel poorly? _____
What foods make you feel good? _____
Any special diet or restrictions? _____
Describe your relationship with food? _____
What is your typical breakfast? _____
Lunch? _____
Dinner? _____
Dessert? _____
Snacks? How/often time of day? _____
Beverages? _____
Drink Soda? ❑ Yes ❑ No Quantity _____ What kinds? _____
Energy Drinks? ❑ Yes ❑ No Quantity _____ What kinds? _____
Drink Coffee? ❑ Yes ❑ No How many times a day? ____ What's in it? _____
Drink Water? ❑ Yes ❑ No Sources of water? _____Amount Daily? _____
Do you use a microwave oven? ❑ Yes ❑ No How often? _____

**Diet – Continued**

Do you heat food in plastic? ❑ Yes ❑ No
Do you use artificial sweetener? ❑ Yes ❑ No
Do you eat fast food? ❑ Yes ❑ No
Do you eat organic? ❑ Yes ❑ No Approximately what percent _____%
How often do you eat out? _____
Please list restaurants _____
History of eating disorders? ❑ Yes ❑ No
Happy with current weight? ❑ Yes ❑ No

**Sleep**

What time do you go to bed?_____ What time do you get up? _____Total hours of sleep? _____
Do you wake feeling refreshed? ❑ Yes ❑ No
Do you sleep straight through the night? ❑ Yes ❑ No
If you wake up in the middle of the night, are you able to fall back to sleep? ❑ Yes ❑ No
Do you keep your cell phone in your bedroom? ❑ Yes ❑ No
Do you watch TV in the bedroom? ❑ Yes ❑ No
Are you on the computer in the bed? ❑ Yes ❑ No
Have you been told you snore? ❑ Yes ❑ No
Do you have sleep apnea? ❑ Yes ❑ No
How often do you get up to urinate at night? _____

| KNOWN TOXIC AND ENVIRONMENTAL EXPOSURES | YES/DETAILS |
|---|---|
| Any water damage in the house? | ❑ |
| Any visible mold? | ❑ |
| Do you eat tuna or other fish? What type:_____ How often?_____ | ❑ |
| Do you use a fireplace or wood stove? | ❑ Type _____ |
| Any implants, artificial joints or plates in body. Please explain | ❑ _____ |
| Do you use fabric softener? | ❑ |
| Do you spray your yard with pesticides? | ❑ |
| Do you wear dry cleaned clothes? | ❑ |
| Do you sleep with an electric blanket? | ❑ |
| Do you use nail polish or artificial nails? | ❑ |
| Do your pets wear flea collars? | ❑ |
| Is your house near power lines? | ❑ |
| Do you use mothballs? Scented candles? | ❑ _____ |
| Do you use air fresheners? | ❑ |
| Do you have any of the following<br>New carpet, new furniture, new paint, new car? | ❑ _____ |
| Do you color your hair? | ❑ |
| Do you live near a golf course? Do you play golf? | ❑ _____ |
| Are you exposed to second hand smoke? | ❑ _____ |
| Any hobbies with chemical exposure (e.g. glues, paints)? | ❑ _____ |
| Have you ever had an adverse reaction to vaccinations or flu shots? | ❑ |
| Dental Exposures. Do you have any | |
| Root canals? | ❑ _____ |
| Implants? Crowns? | ❑ _____ |
| Metal fillings? | ❑ _____ |
| If removed, was it done safely? How long ago? | ❑ _____ |
| Do you live close to a freeway? | ❑ |
| Do you live near industrial areas? | ❑ |
| Do you have a heightened sense of smell? | ❑ |
| Do you smell things others can't smell? | ❑ |
| Do you cook with aluminum pans and/or nonstick cookware? | ❑ _____ |
| Is your cooking stove gas or electric? | ❑ _____ |
| Is your home heat source gas, electric, propane, other? | ❑ _____ |

**REVIEW OF SYSTEMS** – Check/Circle appropriate responses below

| General | YES | NOTES | Mouth-Continued | YES |
|---|---|---|---|---|
| Weakness | ☐ | | Persistent hoarseness | ☐ |
| Fatigue | ☐ | | Floss daily | ☐ |
| Change in weight | ☐ | | Regular dental checkups | ☐ |
| Change in appetite | ☐ | | Metallic taste | ☐ |
| Change in sleeping habits | ☐ | | Dry mouth | ☐ |
| Chill, fever, night sweats | ☐ | | Dental Issues | ☐ |
| **Head** | | | **Neck** | |
| Head Injury | ☐ | | Pain | ☐ |
| Headaches | ☐ | | Stiff neck | ☐ |
| Dizziness | ☐ | | Injury | ☐ |
| Light headed | ☐ | | **Respiratory** | |
| Migraines | ☐ | | Asthma | ☐ |
| **Eyes** | | | Bronchitis | ☐ |
| Glasses/Contacts | ☐ | | Pneumonia | ☐ |
| Reading Glasses | ☐ | | TB | ☐ |
| Last eye exam | _____ | | Chronic cough | ☐ |
| Sensitive to light | ☐ | | Cough up blood | ☐ |
| Glaucoma | ☐ | | Phlegm color | ☐ |
| Cataracts | ☐ | | Shortness of breath | _____ |
| Dry eyes | ☐ | | Wheezing | ☐ |
| Vision changes | ☐ | | **Cardiac** | |
| Bags under eyes | ☐ | | High Blood Pressure | ☐ |
| Dark circles under eyes | ☐ | | Chest pain | ☐ |
| **Ears** | | | Palpitations | ☐ |
| Earaches | ☐ | | Murmur | ☐ |
| Tubes in ears | ☐ | | Angina | ☐ |
| Hearing changes | ☐ | | Varicose veins | ☐ |
| Ringing in ears | ☐ | | **Digestive Tract** | |
| Vertigo | ☐ | | Stomach pain | ☐ |
| Excess wax | ☐ | | Gas/Bloating | ☐ |
| Itchy ears | ☐ | | Heartburn | ☐ |
| **Nose** | | | Nausea | ☐ |
| Sinusitis | ☐ | | Belching | ☐ |
| Runny nose | ☐ | | Ulcers | ☐ |
| Itchy nose | ☐ | | Bowel Movement frequency | _____ |
| Bloody nose | ☐ | | Constipation | ☐ |
| Injury | ☐ | | Diarrhea | ☐ |
| Allergies | ☐ | | Undigested food in stool | ☐ |
| Increased smell | ☐ | | Light colored stool | ☐ |
| Decreased smell | ☐ | | Dark color stool | ☐ |
| Post nasal drip | ☐ | | Blood in stool | ☐ |
| **Mouth** | | | Hemorrhoids | ☐ |
| Bleeding gums | ☐ | | Mucous in stool | ☐ |
| Cold Sores | ☐ | | Hepatitis | ☐ |
| Herpes | ☐ | | Still have Gallbladder | ☐ |
| Frequent sore throats | ☐ | | Colonoscopy | ☐ |
| Strep throat | ☐ | | Have you used antibiotics | ☐ |
| TMJ | ☐ | | How many rounds | _____ |

**REVIEW OF SYSTEMS-Continued.** Check/Circle appropriate responses below

| Genito-Urinary | YES | NOTES |
|---|---|---|
| Blood in urine | ☐ | |
| Urinary Tract Infections | ☐ | |
| Pain with urination | ☐ | |
| Color of urine | | |
| Fully empty your bladder | ☐ | |
| Sexual Preference<br>☐ Male ☐ Female ☐ Both | | |
| Kidney Stones | ☐ | |
| Incontinence | ☐ | |
| History of STD's | | Type_____ |
| Poor Libido | ☐ | |
| **Females** | | |
| Age menses began | _____ | |
| Age ended | _____ | |
| Number of days bleeding<br>☐ heavy ☐ clots ☐ light ☐ average | | |
| Days between cycles | _____ | |
| PMS cramps | ☐ | |
| Number of pregnancies | _____ | |
| Number of births | _____ | |
| Complications | ☐ | |
| Hysterectomy | ☐ | ☐ hypo ☐ hyper |
| Hormone replacement | ☐ | List_____ |
| Pain with intercourse | ☐ | |
| Night sweats | ☐ | |
| Hot flashes | ☐ | |
| Vaginal dryness | ☐ | |
| Changes in breasts | ☐ | ☐ Lumps ☐ Dimpling ☐ Pain |
| Nipple discharge | ☐ | |
| Yeast infections | ☐ | |
| Endometriosis | ☐ | |
| Fibroids | ☐ | |
| Ovarian cysts | ☐ | |
| Last Pap exam | _____ | |
| Abnormal Pap exam | ☐ | |
| Use contraception | ☐ | Birth Control_____ |
| Last mammogram | _____ | |
| **Males** | | Type_____ |
| Last prostate exam | _____ | |
| PSA level | _____ | |
| Erectile Dysfunction | ☐ | |
| Use contraception | ☐ | Type_____ |
| **Skeletal** | | |
| Pain | ☐ | Location _____ |
| Stiffness | ☐ | Location _____ |
| Swelling | ☐ | Location _____ |
| Arthritis | ☐ | Location _____ |
| Osteopenia | ☐ | |
| Osteoporosis | ☐ | |
| Latest Dexa Scan | _____ | |

| Nervous system | YES |
|---|---|
| Numbness | ☐ |
| Tingling | ☐ |
| Seizures | ☐ |
| Black outs | ☐ |
| Anxiety | ☐ |
| Poor memory | ☐ |
| Nervousness | ☐ |
| Panic Attacks | ☐ |
| Hyperactivity | ☐ |
| Irritable | ☐ |
| Poor attention span | ☐ |
| Brain fog | ☐ |
| **Endocrine System** | |
| Tolerate extreme heat | ☐ |
| Get colder than others | ☐ |
| Have excessive thirst | ☐ |
| Hair Loss | ☐ |
| Hypoglycemia | ☐ |
| How do you feel if you miss a meal?<br>_____ | |
| Fatigue | ☐ |
| Thyroid Issues | ☐ |
| **Skin** | |
| Rashes | ☐ |
| Itchy | ☐ |
| Dry | ☐ |
| Acne | ☐ |
| Skin tags | ☐ |
| Bruise easily | ☐ |
| Unusual growth or moles | ☐ |
| Sweat excessively | ☐ |
| Do not sweat easily | ☐ |
| **Other** | |
| Last time you felt great?<br><br>I have never been well since: | |
| **Comments:** | |