Patient name

_____ Date of First Visit _____

Address _____

Telephone # (home)_____ (cell)_____

Can I leave a message with detailed information about your health? _____

Email:_____

Age _____ Date of Birth _____ Gender_____

Ethnicity_____ Race _____ Preferred Language _____

Marital Status_____ I live with_____

Occupation _____ Hours per week _____ Retired _____

Emergency Contact _____Relationship _____ Phone _____

Who is your Primary Care Provider?_____

When and where did you last receive health care?_____

What was the reason?_____

Insurance Company_____ Subscriber ID # _____Group #_____

Primary Subscriber Name_____ Date of Birth _____

How did you hear about Red Blossom Medicine? _____

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

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

General

Weight_____ lb.. Height_____

What is the most you have ever weighed, and when?_____

Have you received the standard schedule of immunizations for your generation? _____

If not, how was it different?_____

Have you received any extra immunizations due to travel or military service? _____

If so, which vaccines?_____

Any significant childhood illnesses? _____

Any accidents to tailbone or head?_____

Current Medications					
Laxatives		Pain relievers		Antacids	
Cortisone		Sleeping Pills		Thyroid medications	

Supplements:	

Allergies Are you hypersensitive or intolerant to:

Any drugs?_____

Any foods?_____

Any environmentals?_____

Hospitalization and Surgery

What hospitalizations or surgeries have you had? Please list the date.

_____

_____

X-rays and Special Studies

X-rays, CAT scans, MRI, sonograms, Mammograms, EKGs, Bone Density, etc.

_____

_____

_____

Family History

	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Age (if living)								
Health (G=good, P=poor)								
Age at death (if deceased)								
Cause of Death								
Check (√)those Applicable								
Cancer - what type?								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Epilepsy								
Mental Illness								
Allergies/Hay-fever/Hives								
Asthma								
Eczema								
Anemia								
Kidney Disease								
Liver Disease								
Tuberculosis								
Reproductive Organ Illness								
other illnesses not listed								
extended family illnesses								

REVIEW OF SYSTEMS:

Please differentiate symptoms: (Y)es for present and (N) for Never or (P) for Past and Significant.

Immune					
Chronic fatigue syndrome	Y N P	Chronic infections	Y N P	Slow wound healing	Y N P
Chronic swollen glands	Y N P	Auto-immune disease	Y N P	Food Allergies	Y N P
Blood					
Easy bleeding/bruising	Y N P	Varicose veins	Y N P	Cold hands/feet	Y N P
Deep leg pain	Y N P	Anemia	Y N P	swelling in ankles	Y N P
Skin					
Rashes	Y N P	Acne, pimples, boils	Y N P	Hair loss	Y N P
Itching	Y N P	Color Change	Y N P	Night sweats	Y N P
Head					
Headaches	Y N P	Migraines	Y N P	Head Injury	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	Y N P	Double vision	Y N P
Glaucoma	Y N P	Dryness	Y N P	Infection	Y N P
Ears					
Impaired hearing	Y N P	Ringing	Y N P	Earaches	Y N P
Pain	Y N P	Excessive Wax	Y N P		
Nose & 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 & Throat					
Frequent sore throat	Y N P	sore tongue	Y N P	Teeth grinding	Y N P
Sore lips	Y N P	Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Jaw clicks	Y N P	Jaw/TMJ problems	Y N P
Neck					
Lumps	Y N P	Swollen glands	Y N P	Goiter	Y N P
Pain	Y N P	Stiffness	Y N P		
Respiratory					
Cough	Y N P	Tuberculosis	Y N P	Spitting up blood	Y N P
Wheezing	Y N P	Asthma	Y N P	Bronchitis	Y N P
Short of breath lying down	Y N P	Pleurisy	Y N P	Emphysema	Y N P
Difficulty breathing	Y N P	Pain on breathing	Y N P	Pneumonia	Y N P
Cardiovascular					
Heart disease	Y N P	Chest pain	Y N P	Murmurs	Y N P
High blood pressure	Y N P	Low blood pressure	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Phlebitis	Y N P	Blood clots	Y N P
Gastrointestinal					
Rectocele	Y N P	Rectal Incontinence	Y N P	Liver disease	Y N P
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N P
Change in appetite	Y N P	Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Blood in stool	Y N P	Pain or cramps	Y N P
Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Gall bladder disease	Y N P	Black stools	Y N P	Ulcer	Y N P
Jaundice (yellow skin)	Y N P	Fissures	Y N P	Hemorrhoids	Y N P
Bowel movements	how often?		Loose/formed?	Is this a change?	
Urinary					
Pain on urination	Y N P	Increased frequency	Y N P	Incontinence	Y N P
Frequency at night	Y N P	Frequent infections	Y N P	Kidney stones	Y N P

Musculoskeletal											
MVA - car crashes	Y	N	P	Injury to pelvic bones	Y	N	P	Injury to tailbone	Y	N	P
Joint pain or stiffness	Y	N	P	Broken bones	Y	N	P	Sacrum Injury	Y	N	P
Muscle spasms/cramps	Y	N	P	Low back pain	Y	N	P	Upper Back Pain	Y	N	P
Arthritis	Y	N	P	Weakness	Y	N	P	Sciatica	Y	N	P
Neurologic											
Seizures	Y	N	P	Paralysis	Y	N	P	Muscle weakness	Y	N	P
Numbness	Y	N	P	Tingling	Y	N	P	Easily stressed	Y	N	P
Vertigo or dizziness	Y	N	P	Loss of balance	Y	N	P	Amnesia	Y	N	P
Endocrine											
Hypothyroid	Y	N	P	Hyperthyroid	Y	N	P	Heat/Cold intolerance	Y	N	P
Diabetes	Y	N	P	Excessive thirst	Y	N	P	Hypoglycemia	Y	N	P
Weight loss/gain	Y	N	P	Fatigue	Y	N	P	Seasonal Depression	Y	N	P
Mental & Emotional											
Treated for emotional problems	Y	N	P	Considered/ Attempted Suicide	Y	N	P	Anxiety or Nervousness	Y	N	P
Mood swings	Y	N	P	Depression	Y	N	P	Memory problems	Y	N	P
Poor concentration	Y	N	P	Tension	Y	N	P	History of Abuse	Y	N	P
Trauma	Y	N	P	PTSD	Y	N	P				
STIs											
Genital warts	Y	N	P	HPV	Y	N	P	Chlamydia	Y	N	P
Herpes	Y	N	P	Syphilis	Y	N	P	Gonorrhea	Y	N	P
Male Reproduction											
Testicular masses	Y	N	P	Testicular pain	Y	N	P	Hernias	Y	N	P
Prostate disease	Y	N	P	Past Infections	Y	N	P	Sores	Y	N	P
Premature ejaculation	Y	N	P	Impotence	Y	N	P	Discharge	Y	N	P
Are you sexually active?				Sexual orientation?				Birth control type?			
Female Reproductive											
Age of first menses				Are cycles regular?				How many days between menses?			
How many days of bleeding?				Clotting	Y	N	P	Dark, Thick Blood	Y	N	P
Bleeding between cycles	Y	N	P	Painful menses	Y	N	P	Bloating	Y	N	P
Heavy or excessive flow	Y	N	P	Light flow	Y	N	P	Dizziness with menses	Y	N	P
PMS symptoms?				Cervical Fluid with ovulation?				Other vaginal discharge?			
Recurrent Ovarian Pain	Y	N	P	Ovulation Pain	Y	N	P	Ovulation Bleeding	Y	N	P
Failure to Ovulate	Y	N	P	Ovarian cysts	Y	N	P	Ovarian Cancer	Y	N	P
Pain during intercourse	Y	N	P	Dry Vagina	Y	N	P	Vaginitis	Y	N	P
STI	Y	N	P	PID	Y	N	P	Abnormal PAP/date			
Endometriosis	Y	N	P	Cervical Dysplasia	Y	N	P	HPV	Y	N	P
Fibroids	Y	N	P	Cancer of Uterus	Y	N	P	Tipped Uterus?			
Contraception				What type?							
Number of pregnancies				# of Live births				# of miscarriages			
Number of abortions				Birthing Trauma?				Pre-term infants			
Difficulty Conceiving				Fertility Charting				Sexual orientation?			

Breast pain/tenderness	Y N P	Breast lumps	Y N P	Nipple discharge	Y N P
Breast feeding	Y N P	Breast self-exams?			
Menopause		Hot Flashes	Y N P	Insomnia	Y N P
Age of last menses		Libido?		Spotting/flooding	Y N P

Past & Present Use of Contraception: List length of time using method

Pill	Shot	Patch	Ring
Diaphragm	Cap	Condoms	FAM
IUD - copper	IUD - Hormonal	Abstinence	

If you are under treatment for fertility, please describe your fertility treatment to date:

_____

_____

_Trauma

Do you have a history of rape or trauma? _____

If so, what ages did this occur?_____

How have you healed from this?_____

Spiritual:

How does your condition affect you? _____

_____

What do you think is happening? _____

_____

Why? _____

Do you have a spiritual practice?_____

Is there any information about your health you would like to add? _____

_____

CONSENT TO TREATMENT

I, the undersigned, understand that methods of evaluation used in this practice may include, but are not limited to, physical exams (vitals, musculoskeletal, EENT, heart and lung, orthopedic, dermatologic, and neurological assessments) and diagnostic procedures (including venipuncture, diagnostic imaging, and laboratory evaluation of blood, urine, stool, and saliva).

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, naturopathic medicine, the Arvigo Techniques of Maya Abdominal Therapies, herbal therapy, homeopathy, massage, hydrotherapy, nutritional supplements, pharmaceutical prescriptions, sauna therapy, and lifestyle and nutritional counseling.

I understand that naturopathic medicine, The Arvigo Techniques, herbal therapy, homeopathy, massage, hydrotherapy, nutritional supplements, sauna therapy, pharmaceutical prescriptions, and nutritional counseling are safe methods of treatment. Potential risks are uncommon but may include nausea, headache, stomachache, vomiting, diarrhea, rashes, hives, or dizziness. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify Dr Sarah Wylie should I become pregnant or if I am in the process of trying to get pregnant so that she can avoid treatments, medications, supplements, and herbs that could induce miscarriage. Otherwise, Naturopathic medical treatment can be very beneficial in the pregnancy and birthing process. I understand that herbal and nutritional supplements recommended to me by Dr Sarah Wylie are safe in the recommended doses. Large doses of herbs or supplements taken without my practitioner's recommendation may be toxic, and some herbs and supplements are inappropriate during pregnancy. Some possible side effects of herbs or supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and dizziness. I understand that if I experience any adverse effects from herbs, supplements, or medications prescribed by Dr Sarah Wylie that I must stop taking these herbs, supplements, or medications and notify Dr Sarah Wylie as soon as I experience any discomfort or adverse reactions.

I understand that Dr Sarah Wylie may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with Dr Sarah Wylie before signing if I so choose. However, I do not expect Dr Wylie to be able to anticipate and explain all possible risks and complications of treatment. I rely on Dr Sarah Wylie to exercise her judgment in my best interest during the course of treatment, based upon the facts then known.

_____ Patient Signature Date