Ocean's Way Naturopathic
& Acupuncture Clinic

644 SW Coast Hwy, Suite D
Newport, OR 97365
541-574-6000

Name: _____Today's Date_____

Address: _____ Age: _____ Date of Birth_____

City: _____ State_____ Zip Code_____

Telephone #: ____--____--_____ Home _____--_____--_____ Work Male____ Female_____

Email address (optional)_____
What are your concerns for which you are seeking naturopathic or acupuncture care?

1._____

2._____

3._____

What medications are you currently taking:
_____

_____

_____

What supplements are you currently taking:

_____

_____

_____

Occupation: _____ Employer: _____

Social Security number: _____

In case of emergency contact: _____ phone: _____

Education: _____ Marital status: _____

Living with: Partner___ Parents____ Children_____ Friends_____ Alone____ Other_____

How did you hear about this clinic? _____

Health History:

Are you currently receiving health care? _____ If so, where _____

Last visit with a medical professional_____. Reason_____

Do you have any contagious diseases at this time? _____

Weight_____lbs. Weight 1 year ago _____ lbs. Highest Weight _____ lbs.

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

Please list any hospitalizations or surgeries you have had: _____

_____

_____

_____

Please list any allergies to medications, food or environmental substances:

_____

_____

_____

Please indicate any immunizations you have received:

_____ Polio _____ Pertussis _____ Measles/Mumps/Rubella

_____Tetanus ____ ___ Diphtheria ____ ___ Other

Please indicate any diagnostic imaging studies you have had:

_____ X-rays _____ Electrocardiogram _____ MRI

_____ CT scan _____ Electroencephalogram _____ Mammogram

_____ Other: _____

Please note any environmental toxin exposures that you are aware of: _____

_____

_____

Family history

Please indicate the health status of your family:

	Father	Mother	Brothers	Sisters	Grandfather	Grandmother
Current Age or Age at death						
Cause of death						
Condition of Health (Poor or Good)						

Please indicate if you or a family member has ever had any of these diseases and indicate who:

Cancer_____

Diabetes_____

Heart Disease _____

High Blood Pressure_____

Stroke_____

Epilepsy_____

Mental Illness_____

Asthma, emphysema_____

Hayfever_____

Anemia _____

Kidney disease or stones_____

Gall Bladder disease_____

Ulcer_____

Personal History **Please indicate if you have had any of the following:**

Pneumonia/Bronchitis_____ **Tuberculosi s**_____ **Rheumatic fever**_____

Pleurisy _____ **Hemorrhoids** _____ **Varicose veins**_____ **Throbophlebitis** _____

Hypothyroid _____ **Hyperthyroid** _____ **Addison or Graves's disease** _____**Goiter** _____

Rheumatoid Arthritis _____ **Osteoarthritis** _____**Broken bones** _____ **Head Injury**_____

Heart murmur _____ **Heart attack** _____**Cataracts** _____ **Glaucoma** _____

Dermatitis_____

Health Habits

Do you eat three meals a day? Y N **Do you sleep well? Y N**

Do you wake feeling rested? Y N **How many hours sleep on average do you get? _____**

Do you enjoy you work? Y N **Do you take vacations? Y N**

Do you spend time outside? Y N **Do you read for pleasure? Y N How often? _____**

Do you watch TV? Y N How many hours per week? _____

Do you exercise? Y N How often? _____ What kind? _____

Do you use recreational drugs? Y N If yes, how often? _____

Do you drink alcohol ? Y N How much per week? _____ Ever treated for substance abuse? Y N

Do you eat in restaurants ? Y N **Do you diet to lose weight? Y N**

Do you add salt to your food? Y N **Do you eat refined sugar? Y N**

Do you drink coffee? Y N How much per day? _____

Do you drink sodas? Y N How many per day? _____

Do you drink teas? Y N How much per day? _____

Do you use tobacco? Y N What form? _____ How much per day? _____

Do you have a religious or spiritual practice? Y N If so, what? _____

Do you have supportive relationships? Y N

Are you hearing impaired? Y N **Are you visually impaired? Y N**

What are your favorite activities: _____

_____

_____

How does your current medical condition affect you? _____

_____

_____

_____

What do you think is the cause? _____

_____

How much change are you willing to make to improve you health? Some__ Complete___ Minimal___

Is there any other information you would like to add? _____

_____

_____

Please check any symptoms you have had and indicate whether it is current (C) or in the past (P):

Female Reproductive

Bleeding between periods _____

Pain during intercourse _____

Irregular cycles _____

Excessive flow _____

Painful menses ____

Menopausal symptoms _____

Sexually transmitted diseases ____

Sexual difficulties _____

Are you sexually active? _____

Male Reproductive

Hernias _____

Testicular masses _____

Testicular pain _____

Prostate disease _____

Discharge or sores ____

Andropause symptoms _____

Sexually transmitted diseases _____

Sexual difficulties _____

Are you sexually active? _____

Menstrual history

Age at first menses _____

Are you having regular cycles? _____

Average length of cycle _____

Average length of bleeding _____

Date of the first day of last menses _____

Reproductive history

Do you use birth control? _____ If so, method _____

Number of pregnancies _____

Number of live births _____

Number of miscarriages _____

Any difficulty conceiving? _____

Breasts

Any lumps? _____ Pain or tenderness _____ Discharge _____

Do you do self exams? _____

Review of Systems **Please mark any symptoms you have had with either (C) for current or (P) in the past:**

Mouth & Throat **P**

_____**Chronic coughing** ____

_____**Gagging** ____

_____**Frequent need to clear throat**

_____**Swollen tongue, gums or lips** _____

_____**Canker sores** ____

Nose

_____**Stuffy Nose**

_____**Sinus Problems** _____

_____ **Sneezing attacks** _____

_____ **Excessive mucus formation**

_____ **Frequent colds** ____

_____ **Nose bleeds** ____

Skin

_____ **Acne, boils** ____

_____ **Hives, rash, dry skin**

_____**Hair loss** _____

_____**Flushing or hot flashes**

_____**Night Sweats** _____**Frequent**

_____**Itching** ____

_____**Color change** ____

_____**Lumps**

_____**Rashes** ____

_____ **Hay Fever** _____

Weight ____

_____ **Binge eating/drinking**

_____ **Craving certain foods**

_____ **Compulsive eating** _____

_____ **Water retention** ____

_____ **Underweight**

Urinary ____

_____ **Pain on urination**

_____ **Increased frequency of urination** _____

_____ **Frequency at night** _____

_____ **Incontinence** ____

eripheral Vascular

___ **Deep leg pain**

___ **Cold hands/feet**

Neurological

Seizures

___ **Paralysis**

Endocrine

_____ **Heat or cold intolerance**

Excessive Thirst

Excessive hunger

Blood

___**Anemia**

___ **Easy bleeding/bruising**

Neck

___ **Lumps**

_____ **Swollen Glands**

Pain or Stiffness

Other

Illness

___**Frequent or urgent urination**

___**Genital itch or discharge**

Mind

___ **Poor memory**

Confusion, poor comprehension

___ **Poor coordination**

_____ **Difficulty making decisions**

_____ **Stuttering or stammering**

Slurred speech

___ **Learning disabilities**

Emotional

___ **Mood Swings**

_____ **Anxiety or nervousness**

Anger/Irritability

Depression

___ **Tension**

Please mark any symptoms you have had with either (C) for current or (P) in the past:

Digestion

_____ **Nausea/vomiting**
_____ **Diarrhea**
_____ **Constipation**
_____ **Bloating**
_____ **Gas or Belching**
_____ **Heartburn**
_____ **Trouble Swallowing**
_____ **Jaundice**
_____ **Change in thirst**
_____ **Change in appetite**
_____ **Blood in stool**
_____ **Irregular Bowel Movements**

Ears

_____ **Itchy ears**
_____ **Earache/Infections**
_____ **Drainage from ears**
_____ **Ringing in ears/hearing loss**
_____ **Dizziness**

Eyes

_____ **Watery/itchy eyes**
_____ **Swollen/reddened/sticky eyes**
_____ **Bags or dark circles under eyes**
_____ **Blurred, tunnel, double vision**
_____ **Eye pain**
_____ **Dry eyes**

Energy

_____ **Fatigue/sluggishness**
_____ **Apathy/lethargy**
_____ **Hyperactivity**
_____ **Restlessness**

Head

___ **Headache/Migraines**
Faintness
Dizziness
___ **Insomnia**

Heart

_____ **Irregular or skipped heartbeat**
___ **Rapid or pounding heartbeat**
___ **Chest pain**
_____ **Swelling in ankles**
_____ **Elevated blood pressure**

Joints/Muscles

_____ **Pain or ache in joints**
Arthritis
Stiffness/limited movement
_____ **Pain or ache in muscles**
_____ **Feeling of weakness or tiredness**
_____ **Numbness or tingling**

Lungs

_____ **Chest congestion**
_____ **Deep chest coughing**
_____ **Shortness of Breath**
_____ **Difficulty Breathing**
_____ **Painful Breathing**
___ **Sputum**
_____ **Spitting up blood**
_____ **Wheezing**