Andrew Kim, ND – GroundSpring Healing Center

8283 SW Barbur Blvd, Portland, Oregon 97219 phone: 503-244-7331 fax: 503-662-6344
drkimnd@naturaltraditionsportland.com

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: _____ _____

(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: _____

_____

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 this clinic?

- What do you know about our approach?

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

- What long term expectations do you have from working with our clinic?

- What 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?

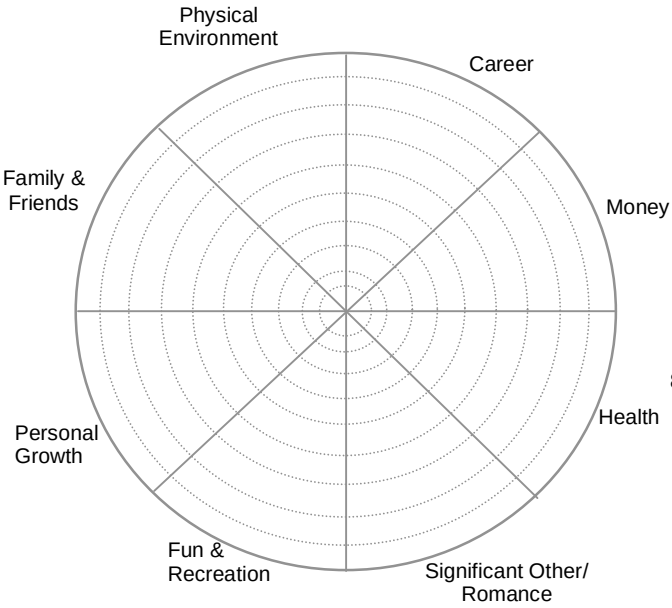
6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wheel of Balance

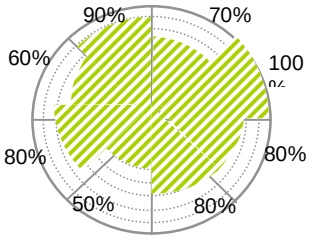
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

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.



Example:



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 (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, EEG, EKG's have you had?

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmentals 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? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

FOR THE FOLLOWING, PLEASE CIRCLE

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

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 dependence?	Y N P		
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
Treated for alcoholism?	Y N P	Do you go on diets often?	Y N
Do you use tobacco?	Y N P	Do you eat out often?	Y N
Smoked previously?	Y N P	Do you drink coffee?	Y N P
How many years? _____		Drink black/green tea?	Y N P
How many packs per day? _____		Do you drink cola/other sodas?	Y N P
		Do you eat refined sugar?	Y N P
		Do you add salt?	Y N P

Do you have a religious or spiritual practice? Y N

If yes, what? _____

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	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

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 <u>have now</u> N=Never had P=<u>Significant</u> 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? _____
Age of last menses? (if menopausal) _____
Length of cycle? _____ days
Duration of menses? _____ days

Painful menses?	Y	N	P
Heavy or excessive flow?	Y	N	P
PMS?	Y	N	P

If yes, what are your symptoms?

_____

_____

Endometriosis?	Y	N	P
Ovarian cysts?	Y	N	P
Difficulty conceiving?	Y	N	P
Cervical Dysplasia?	Y	N	P
Sexual difficulties?	Y	N	P
Gonorrhea?	Y	N	P
Herpes?	Y	N	P
Are you sexually active?	Y	N	
Do you do breast self exams?	Y	N	P
Breast pain/tenderness?	Y	N	P

Date of last annual exam/ PAP _____

Are cycles regular?	Y	N	
Bleeding between cycles?	Y	N	P
Pain during intercourse?	Y	N	P
Clotting?	Y	N	P
Discharge?	Y	N	P
Birth control?	Y	N	P

What type? _____
Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____

Menopausal symptoms?	Y	N	P
Abnormal PAP?	Y	N	P
Chlamydia?	Y	N	P
Condyloma?	Y	N	P
Syphilis?	Y	N	P

Sexual orientation: _____

Breast lumps?	Y	N	P
Nipple discharge?	Y	N	P

<u>Is there anything else you would like to add or comment on?</u>