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 _____
Age _____ Date of Birth ____ /_____ /_____ Gender: _____
Address _____
City _____ State _____ Zip Code_____
Telephone # (home)_____ (work) _____
E-mail address _____

Occupation _____ Hours per week _____ Retired ___
Employer _____
(Work address) _____

Married ___ Separated ___ Divorced ___Widowed ___ Single ___ Partnership ___
Live with: Spouse ____Partner____Parents_____Children____Friends___Alone____

Which doctor referred you? _____

What are your most important health problems that your doctor is treating you for? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

Allergies

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals? _____

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Tobacco	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) _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

GENERAL

Weight _____lbs. Weight 1 year ago _____ lbs.
Maximum Weight _____ When _____
Height _____
When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE

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

MENTAL/EMOTIONAL

Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

ENDOCRINE

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

IMMUNE

Vaccinations?	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

SKIN

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P

HEAD

Headaches?	Y N P	Migraines?	Y N P
Head injury?	Y N P		

EARS

Earaches?	Y N P	Impaired hearing?	Y N P
Dizziness?	Y N P	Ringing?	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	Sore tongue/lips?	Y N P

RESPIRATORY

Cough?	Y N P	Wheezing?	Y N P
Asthma?	Y N P	Bronchitis?	Y N P

CARDIOVASCULAR

Heart disease?	Y N P	High/Low Blood Pressure?	Y N P
Palpitations/Fluttering?	Y N P		

GASTROINTESTINAL

Heartburn?	Y N P	Belching or passing gas?	Y N P
Change in thirst?	Y N P	Change in appetite?	Y N P
Bowel Movements		Constipation?	Y N P
How often? _____		Diarrhea?	Y N P
Is this a change? _____			

URINARY

Increased frequency?	Y N P	Frequency at night?	Y N P
Frequent infections?	Y N P		

MUSCULOSKELETAL

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Muscle spasms or cramps?	Y N P		

MALE REPRODUCTION

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Herpes?	Y N P	Discharge or sores?	Y N P

FEMALE REPRODUCTION/BREASTS

Age of first menses? _____
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?
_____
_____
_____
_____

Are cycles regular? Y N P
Bleeding between cycles? Y N P
Pain during intercourse? Y N P
Clotting during menses? 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 _____

Cervical Dysplasia? Y N P
Herpes? Y N P
Endometriosis? Y N P
Age of last menses? (if menopausal) _____
Do you do breast self exams? Y N P
Breast pain/tenderness? Y N P

Abnormal PAP? Y N P
Papilloma? Y N P
Ovarian cysts? Y N P
Menopausal symptoms? Y N P
Breast lumps? Y N P
Nipple discharge? Y N P

HABITS

Do you exercise? Y N
If yes, what kind? _____ How often? _____
Average 6-8 hrs. sleep? Y N
Sleep well? Y N
Awaken rested? Y N
Have a supportive relationship? Y N
Any major traumas? Y N P
Have a history of abuse? Y N P
Use recreational drugs? Y N P
Treated for drug dependence? Y N P
Do you eat 3 meals a day? Y N P
Do you eat out often? Y N P
Do you go on diets often? Y N P
Do you drink coffee? Y N P
Do you drink black tea? Y N P
Do you drink cola? Y N P
Do you eat refined sugar? Y N P
Do you add salt? Y N P

Enjoy your work? Y N
Take vacations? Y N
Spend time outside? Y N
Watch television? Y N
how many hours? _____
Read? Y N
how many hours? _____

Use alcoholic beverages? Y N P
Treated for alcoholism? Y N P
Do you use tobacco? Y N P

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