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Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (h): _____ (c): _____ (w): _____

E-mail address: _____

Quarterly E-Newsletter? Yes No Age: _____ Date of Birth: _____

Marital Status: Married Separated Divorced Widowed Single Partnership

Live with: Spouse Partner Parents Children Friends Alone

Occupation: _____ Hours per week: _____ Retired

Employer: _____

Physician: _____ Phone: _____

Address: _____

Who may we thank for referring you? _____

In Emergency Notify: _____ Relationship to patient: _____

Phone: _____

Please list your main health concerns in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

What is your present level of commitment to address underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0 1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in that you believe are unsupportive of your health?

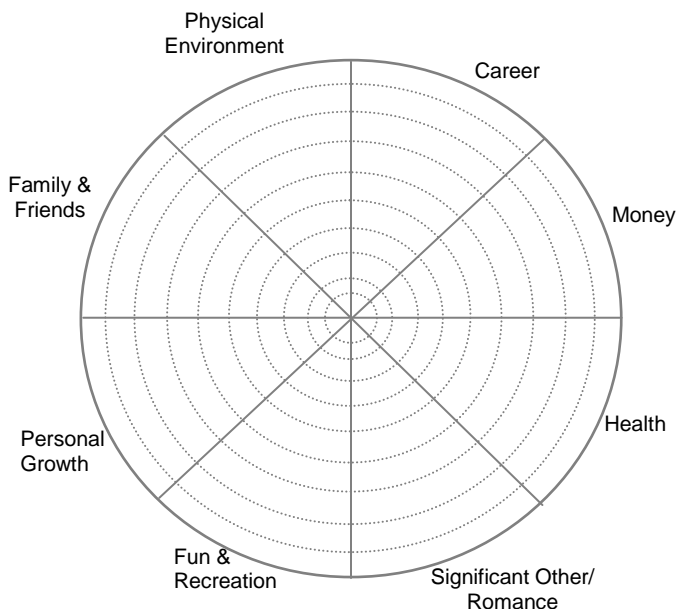
What potential obstacles do you foresee in addressing the lifestyle factors or changes that may be recommended?

Wheel of Balance

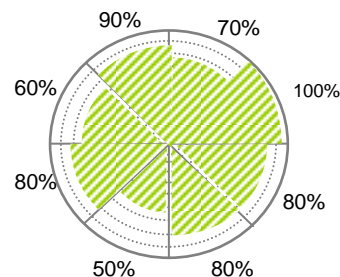
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

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:



Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Number of caffeinated drinks per day: _____

Number of alcoholic drinks per week: _____

Number of times per week alcohol consumed: _____

How often do you eat out? _____

Do you smoke? Yes No Past Amount: _____

Exercise

#of days per week:_____ Length of workout:_____ Type of activity:_____

Sleep

Bedtime: _____ Wake time: _____

Difficulty falling asleep? Yes No

Night time waking? Yes No if yes, what time? _____

Wake up feeling rested? Yes No

General

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight: _____ When: _____

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

Personal History

Please check any conditions or symptoms you have now

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gallbladder Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High/low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Elevated Blood Cholesterol | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerances | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Respiratory Allergies | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Emphysema | | |

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Other _____ |

Childhood Illnesses

Please check any condition you had as a child

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles | <input type="checkbox"/> German measles |

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____	Year
_____	Year
_____	Year

Allergies

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

Current Medications

Please check any of the following medications that you take or use

- | | | |
|--|--|---|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Appetite suppressants | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Sleeping pills |

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking:

1) _____	5) _____
2) _____	6) _____
3) _____	7) _____
4) _____	8) _____

Please check the **first box** if you had this issue in the **past** but do not any longer.
Please check the **second box** if you **currently/recently** have any of these symptoms.

General

- | | | |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Fevers | <input type="checkbox"/> <input type="checkbox"/> Poor sleeping | <input type="checkbox"/> <input type="checkbox"/> Muscle weakness/fatigue |
| <input type="checkbox"/> <input type="checkbox"/> Sweats easily | <input type="checkbox"/> <input type="checkbox"/> Chills | <input type="checkbox"/> <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> <input type="checkbox"/> Localized weakness | <input type="checkbox"/> <input type="checkbox"/> Tremors | <input type="checkbox"/> <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> <input type="checkbox"/> Poor balance | <input type="checkbox"/> <input type="checkbox"/> Cravings |
| <input type="checkbox"/> <input type="checkbox"/> Dental/Gum problems | <input type="checkbox"/> <input type="checkbox"/> Weight loss | <input type="checkbox"/> <input type="checkbox"/> Peculiar tastes/smells |
| <input type="checkbox"/> <input type="checkbox"/> Strong thirst (hot/cold drinks) | <input type="checkbox"/> <input type="checkbox"/> Weight gain | <input type="checkbox"/> <input type="checkbox"/> Sudden energy drop |

Skin and Hair

- | | | |
|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Rashes | <input type="checkbox"/> <input type="checkbox"/> Dermatitis | <input type="checkbox"/> <input type="checkbox"/> Change in skin/hair texture |
| <input type="checkbox"/> <input type="checkbox"/> Itching | <input type="checkbox"/> <input type="checkbox"/> Ulcerations | <input type="checkbox"/> <input type="checkbox"/> Hives/allergic dermatitis |
| <input type="checkbox"/> <input type="checkbox"/> Loss of hair | <input type="checkbox"/> <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> <input type="checkbox"/> Acne | <input type="checkbox"/> <input type="checkbox"/> Recent moles | <input type="checkbox"/> <input type="checkbox"/> Skin discoloration |
| <input type="checkbox"/> <input type="checkbox"/> Weak or ridged nails | <input type="checkbox"/> <input type="checkbox"/> Warts | <input type="checkbox"/> <input type="checkbox"/> Face flushing |
| | | <input type="checkbox"/> <input type="checkbox"/> Fungal infection |

Head, Eyes, Ears, Nose and Throat

- | | | |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> <input type="checkbox"/> Headaches |
| <input type="checkbox"/> <input type="checkbox"/> Glasses | <input type="checkbox"/> <input type="checkbox"/> Eye strain | <input type="checkbox"/> <input type="checkbox"/> Migraines |
| <input type="checkbox"/> <input type="checkbox"/> Poor vision | <input type="checkbox"/> <input type="checkbox"/> Night blindness | <input type="checkbox"/> <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> <input type="checkbox"/> Cataracts | <input type="checkbox"/> <input type="checkbox"/> Blurred vision | <input type="checkbox"/> <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> <input type="checkbox"/> Poor hearing | <input type="checkbox"/> <input type="checkbox"/> Earaches |
| <input type="checkbox"/> <input type="checkbox"/> Sinus problems | <input type="checkbox"/> <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> <input type="checkbox"/> Facial pain | <input type="checkbox"/> <input type="checkbox"/> Recurrent sore throat/colds |
| <input type="checkbox"/> <input type="checkbox"/> Dental problems | <input type="checkbox"/> <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> <input type="checkbox"/> Sores on lips/tongue |

Cardiovascular

- | | | |
|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Chest pain | <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> <input type="checkbox"/> Palpitations at rest |
| <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> <input type="checkbox"/> Swelling of hands/feet |
| <input type="checkbox"/> <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> <input type="checkbox"/> Phlebitis | <input type="checkbox"/> <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> <input type="checkbox"/> Blood clots | <input type="checkbox"/> <input type="checkbox"/> Dizziness |

Respiratory

- | | | |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> <input type="checkbox"/> Coughing blood | <input type="checkbox"/> <input type="checkbox"/> Tight sensation in chest |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Pneumonia | <input type="checkbox"/> <input type="checkbox"/> Pain with deep inhalation |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Difficult inhale/exhale | |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty breathing when lying down | | |
| <input type="checkbox"/> <input type="checkbox"/> Production of phlegm: What color? _____ | | |

Gastrointestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Nausea | <input type="checkbox"/> <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> <input type="checkbox"/> Gas | <input type="checkbox"/> <input type="checkbox"/> Constipation | <input type="checkbox"/> <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> <input type="checkbox"/> Indigestion | <input type="checkbox"/> <input type="checkbox"/> Black stools | <input type="checkbox"/> <input type="checkbox"/> Loose stools (>2 per day) |
| <input type="checkbox"/> <input type="checkbox"/> Bloating | <input type="checkbox"/> <input type="checkbox"/> Blood in stools | <input type="checkbox"/> <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> <input type="checkbox"/> Bad breath | <input type="checkbox"/> <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> <input type="checkbox"/> Acid reflux/GERD | <input type="checkbox"/> <input type="checkbox"/> Poor appetite | <input type="checkbox"/> <input type="checkbox"/> Chronic laxative use |
| <input type="checkbox"/> <input type="checkbox"/> Belching | <input type="checkbox"/> <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> <input type="checkbox"/> Significant thirst |
| <input type="checkbox"/> <input type="checkbox"/> Hernia | <input type="checkbox"/> <input type="checkbox"/> IBS/Crohn's disease | |

Genito-Urinary

- | | | |
|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Frequent urination | <input type="checkbox"/> <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> <input type="checkbox"/> Painful urination | <input type="checkbox"/> <input type="checkbox"/> Blood in urine | <input type="checkbox"/> <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> <input type="checkbox"/> Urgent urination | <input type="checkbox"/> <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> <input type="checkbox"/> Nocturnal emission |
| <input type="checkbox"/> <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> <input type="checkbox"/> Herpes | <input type="checkbox"/> <input type="checkbox"/> Impotence |
| <input type="checkbox"/> <input type="checkbox"/> Copious flow | <input type="checkbox"/> <input type="checkbox"/> STD's | <input type="checkbox"/> <input type="checkbox"/> Pain in testicles |
| <input type="checkbox"/> <input type="checkbox"/> Scanty flow | <input type="checkbox"/> <input type="checkbox"/> Decreased libido | <input type="checkbox"/> <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> <input type="checkbox"/> Dribbling after urination | <input type="checkbox"/> <input type="checkbox"/> Excessive libido | |
| <input type="checkbox"/> <input type="checkbox"/> Night urination: What time? _____ How often? _____ | | |

Gynecological/Reproductive - Females

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> <input type="checkbox"/> Difficult/painful intercourse | <input type="checkbox"/> <input type="checkbox"/> Ovarian cysts | ◆ Age of first menses _____ |
| <input type="checkbox"/> <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> <input type="checkbox"/> Endometriosis | ◆ Date of last menses _____ |
| <input type="checkbox"/> <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> <input type="checkbox"/> Uterine fibroids | ◆ Date of last PAP/Pelvic _____ |
| <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> <input type="checkbox"/> Fibrocystic breast tissue | ◆ # of pregnancies _____ |
| <input type="checkbox"/> <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> <input type="checkbox"/> Polycystic ovarian disease | ◆ # of ectopic pregnancies _____ |
| <input type="checkbox"/> <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> <input type="checkbox"/> Infertility | ◆ # of live births _____ |
| <input type="checkbox"/> <input type="checkbox"/> PMS | | ◆ # of miscarriages _____ |
| Do you practice birth control? _____ | | ◆ # of abortions _____ |
| What type? _____ How long? _____ | | |

Musculoskeletal

- | | | |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Neck pain | <input type="checkbox"/> <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> <input type="checkbox"/> Knee pain | <input type="checkbox"/> <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> <input type="checkbox"/> Hip pain | <input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> <input type="checkbox"/> Tendonitis | <input type="checkbox"/> <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> <input type="checkbox"/> Rotator cuff pain | <input type="checkbox"/> <input type="checkbox"/> Sprains/strains | <input type="checkbox"/> <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) |
| <input type="checkbox"/> <input type="checkbox"/> Back pain: Low ___ Middle ___ Upper ___ | | |

Neuropsychological

- | | | |
|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Seizures | <input type="checkbox"/> <input type="checkbox"/> Concussion | <input type="checkbox"/> <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> <input type="checkbox"/> Anxiety/Panic attacks |
| <input type="checkbox"/> <input type="checkbox"/> Loss of balance | <input type="checkbox"/> <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> <input type="checkbox"/> Depression |
| <input type="checkbox"/> <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> <input type="checkbox"/> Poor memory | <input type="checkbox"/> <input type="checkbox"/> Manic depression |
| <input type="checkbox"/> <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> <input type="checkbox"/> Seasonal Affective Disorder |