

# Doylestown Natural Medicine

140 E. State St. 2<sup>nd</sup> Floor

Doylestown, PA 18901

Dr. Alison Finger, ND

www.doylestownnaturalmedicine.com

215-348-8470

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone # (home): \_\_\_\_\_ (cell): \_\_\_\_\_

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: \_\_\_\_\_ S.S.#: \_\_\_\_\_

(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: \_\_\_\_\_

\_\_\_\_\_

**PLEASE FILL OUT BOTH SIDES OF EACH PAGE**

## 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      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?

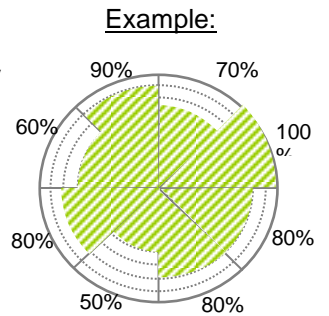
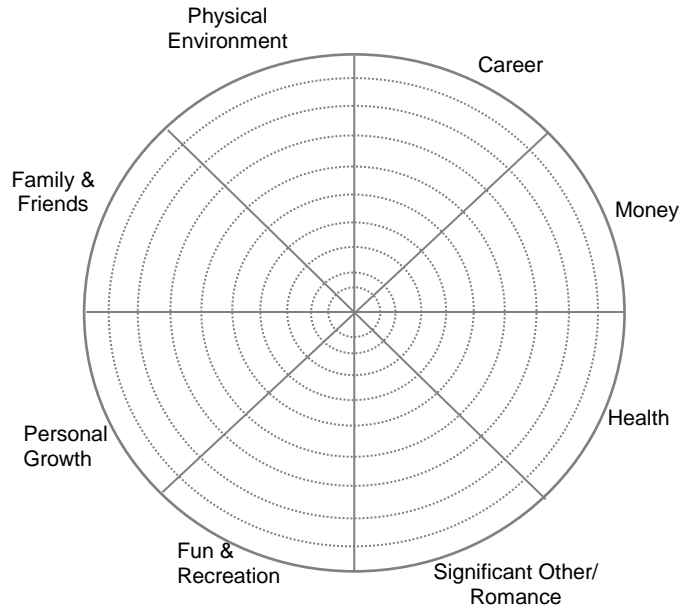
6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

**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.



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? \_\_\_\_\_

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### Childhood Diseases

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 environmental 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

how many hours? \_\_\_\_\_

Been treated for drug dependence? Y   N   P

Use alcoholic beverages?                          Y   N   P

Treated for alcoholism?                              Y   N   P

Do you use tobacco?                                  Y   N   P

Smoked previously?                                      Y   N   P

How many years? \_\_\_\_\_

How many packs per day? \_\_\_\_\_

Do you eat 3 meals a day?                          Y   N

Do you go on diets often?                              Y   N

Do you eat out often?                                  Y   N

Do you drink coffee?                                  Y   N   P

Drink black/green tea?                                  Y   N   P

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

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### 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
Stiffness?	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

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### 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

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### 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? _____		Date of last annual exam/ PAP _____	
Age of last menses? (if menopausal) _____		Are cycles regular?	Y N
Length of cycle? _____ days		Bleeding between cycles?	Y N P
Duration of menses? _____ days		Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms? _____		What type? _____	
_____		Number of pregnancies: _____	
_____		Number of live births: _____	
Endometriosis?	Y N P	Number of miscarriages: _____	
Ovarian cysts?	Y N P	Number of abortions: _____	
Difficulty conceiving?	Y N P	Menopausal symptoms?	Y N P
Cervical Dysplasia?	Y N P	Abnormal PAP?	Y N P
Sexual difficulties?	Y N P	Chlamydia?	Y N P
Gonorrhea?	Y N P	Condyloma?	Y N P
Herpes?	Y N P	Syphilis?	Y N P
Are you sexually active?	Y N	Sexual orientation: _____	
Do you do breast self exams?	Y N P	Breast lumps?	Y N P
Breast pain/tenderness?	Y N P	Nipple discharge?	Y N P

Is there anything else you would like to add or comment on?

**Thank you for your time and effort. I look forward to providing you with the best possible care.**