NORTHVIEW WELLNESS

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NAME:_____ **DOB:**_____

Context of Care

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

1.
2.
3.

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

What is your present level of commitment to addressing any underlying issues that relate to your lifestyle?

Rate from 0 to 10 - 10 being 100% committed

0% 1 2 3 4 5 6 7 8 9 100%

HEALTH & LIFESTYLE

Age:_____ Marital Status: ☐ single ☐ married/partnered ☐ divorced ☐ widowed

# of Children: _____

Have you had unintentional weight gain or loss of 10 or more pounds in the last month?

☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Drug Allergies: ☐ Yes ☐ No

Please list any allergies: _____

Do you have: ☐ Corrective Lenses ☐ Dentures ☐ Hearing Aid

☐ Other Medical Device _____

Occupation:_____ Hours worked per week: _____

Main interests and hobbies:_____

Exercise: ☐ Yes ☐ No If so, what kind and how often: _____

Watch TV: ☐ Yes ☐ No If so, how many hours? _____

Read: ☐ Yes ☐ No If so, how many hours? _____

Do you have a religious or spiritual practice? ☐ Yes ☐ No

If so, what kind?_____

HEALTHCARE STATUS

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom? _____

If not, when and where did you last receive medical or health care?

_____

For what reason were you seen? _____

Have you had any recent lab work done (within the last 6mo)? ☐ Yes ☐ No

If so, where? _____

What are your most important health issues right now? List as many as you can in order of importance.

- _____
- _____
- _____
- _____
- _____
- _____
- _____

What types of therapies have you tried for these problems?

☐ Diet Modification ☐ Fasting ☐ Vitamins/Minerals ☐ Herbs ☐ Homeopathy

☐ Chiropractic ☐ Acupuncture ☐ Conventional Rx ☐ Other: _____

Do you have any known contagious diseases at this time? ☐ Yes ☐ No

If yes, what? _____

Past Serious Illness/Infections

Illness:_____ Year:_____ Illness:_____ Year:_____

Illness:_____ Year:_____ Illness:_____ Year:_____

Illness:_____ Year:_____ Illness:_____ Year:_____

HOSPITALIZATIONS, SURGERY & IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

Procedure:_____ Year: _____ Procedure:_____ Year: _____

Procedure:_____ Year: _____ Procedure:_____ Year: _____

Procedure:_____ Year: _____ Procedure:_____ Year: _____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please check and write who)

☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure
☐ Kidney disease	☐ Epilepsy	☐ Arthritis	☐ Glaucoma
☐ Tuberculosis	☐ Stroke	☐ Anemia	☐ Mental Illness
☐ Asthma	☐ Hay fever	☐ Hives	☐ Depression or Suicide
☐ Eating Disorder	☐ Genetic Disorder	☐ Dementia	☐ Alcoholism / Addiction
☐ Learning Disabilities	☐ Osteoporosis	☐ Migraines	☐ Obesity
☐ Parkinson's	☐ Multiple Sclerosis	☐ Alzheimer's	☐ Other: _____

Other relevant family history? _____

What is your family heritage? _____

CHILDHOOD ILLNESSES

Birth location: _____ Time:_____ Weight: _____

Please mark any diseases you had as a child:

☐ Rheumatic Fever	☐ Diphtheria	☐ Scarlet Fever	☐ Chicken Pox
☐ German Measles	☐ Measles	☐ Mumps	☐ Other:

CURRENT MEDICATIONS

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

• _____ • _____

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____