

Juliette Soihl, ND

Renewed Health ~ 5010 NE 33rd Ave ~ Portland, OR 97211

ADULT INTAKE

Full Legal Name: LAST _____, FIRST _____ M.I. _____
Name I Prefer to Go By _____ Occupation _____
Today's Date (1st Appt.) ____/____/____ AGE ____ Date of Birth ____/____/____ Gender ____

CONTACT INFORMATION

Street Address _____ City _____
State _____ Zip Code _____ E-Mail _____
Day Phone _____ Eve Phone _____ Cell _____
()Single ()Married ()Partnered Name of partner/spouse: _____
Emergency Contact _____ Phone _____ Relationship _____

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 response to the following questions will go a long 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.

Why did you choose to come to this clinic? _____

What do you know about the naturopathic medical approach? _____

What *three* expectations do you have from *this* visit? _____

What *long-term* expectations do you have? _____

What expectations do you have of me personally as your health care provider? _____

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, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? _____

What behaviors or lifestyle habits do you currently engage in regularly that you believe do not support your health? _____

What potential obstacles do you foresee in addressing the factors that may need to change in order to enhance your health? _____

Who do you know that could sincerely and consistently support you with the beneficial changes you could make? _____

Juliette Soihl, ND

Renewed Health ~ 5010 NE 33rd Ave ~ Portland, OR 97211

Your Primary Care Doctor _____ Phone _____
Date last seen and Reason _____
Other Healthcare Provider _____ Phone _____
Date last seen and Reason _____
Other Healthcare Provider _____ Phone _____
Date last seen and 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? Yes / No

If yes, what? _____

FAMILY HISTORY

Do you have a family history of any of the following (please circle)?

High Blood Pressure	Diabetes	Cancer	Tuberculosis	Asthma/Eczema
Heart Disease	Kidney disease	Epilepsy	Arthritis	Hay fever/hives
Heart murmur	Glaucoma	Stroke	Mental Illness	Anemia

Is your father still living? Yes; his age _____ No; age at time of death _____ Cause of death _____

Is your mother still living? Yes; her age _____ No; age at time of death _____ Cause of death _____

Any other relevant family history? _____

What is your family heritage? _____

CHILDHOOD ILLNESSES

Please circle whether you have/had any of the following as a child:

Chicken pox	Diphtheria	German measles	Measles
Rheumatic fever	Mumps	Scarlet fever	Other _____

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, MRI's, EEGs, EKGs have you had?

_____	Year _____	_____	Year _____
_____	Year _____	_____	Year _____
_____	Year _____	_____	Year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental agents or chemicals? _____

Juliette Soihl, ND

Renewed Health ~ 5010 NE 33rd Ave ~ Portland, OR 97211

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives Pain Relievers Antacids Cortisone
Antibiotics Tranquilizers Sleeping pills Thyroid medication
Birth Control Pills Hormone Replacement

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: _____ Weight one year ago: _____

Maximum Weight: _____ When: _____

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

Main interests and hobbies: _____

Exercise: Y / N If so, what kind and how often: _____

Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? _____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

FOR THE FOLLOWING, PLEASE CIRCLE:

Y = a condition you have Now N = Never had P = a significant problem in the Past

GENERAL

Do you sleep well? Y N P

Average 6-8 hours? Y N P

Awake rested? Y N P

Have a supportive relationship? Y N P

Have a history of abuse? Y N P

Experienced a major trauma? Y N P

Use recreational drugs? Y N P

Treated for drug dependence? Y N P

Use alcoholic beverages? Y N P

Use tobacco? Y N P

If in the past, how many years? _____

How many packs per day? _____

Do you enjoy your work? Y N P

Take vacations? Y N P

Spend time outside? Y N P

Eat three meals a day? Y N P

Do you go on diets often? Y N P

ENDOCRINE

Hypothyroid? Y N P

Hypoglycemia? Y N P

Excessive thirst? Y N P

Fatigue? Y N P

Heat or cold intolerance? Y N P

Hyperthyroid? Y N P

Diabetes? Y N P

Excessive hunger? Y N P

Seasonal depression? Y N P

Difficulty exercising? Y N P

RESPIRATORY

Cough? Y N P

Sputum? Y N P

Asthma? Y N P

Wheezing? Y N P

Bronchitis? Y N P

Juliette Soihl, ND

Renewed Health ~ 5010 NE 33rd Ave ~ Portland, OR 97211

GENERAL CONTINUED

Do you eat out often? Y N P
 Do you drink coffee? Y N P
 Drink soda? Y N P
 Do you eat refined sugar? Y N P
 Do you add salt to your food? Y N P

HEAD

Headaches? Y N P
 Migraines? Y N P
 Head injury? Y N P
 Jaw or TMJ problems? Y N P

EARS

Impaired hearing? Y N P
 Ringing in ears? Y N P
 Dizziness? Y N P
 Ear aches? Y N P

EYES

Impaired vision? Y N P
 Cataracts? Y N P
 Glaucoma? Y N P
 Spots in vision? Y N P
 Color blindness? Y N P
 Tearing or dryness? Y N P
 Eye pain or strain? Y N P
 Double vision? Y N P

NOSE AND SINUS

Frequent colds? Y N P
 Stuffiness? Y N P
 Sinus problems? Y N P
 Nose bleeds? Y N P
 Hayfever? Y N P
 Loss of smell? Y N P

MOUTH AND THROAT

Frequent sore throat? Y N P
 Copious saliva? Y N P
 Sore tongue or lips? Y N P
 Hoarseness? Y N P
 Jaw clicks? Y N P
 Teeth grinding? Y N P
 Gum problems? Y N P
 Dental cavities? Y N P

NECK

Lumps in neck? Y N P
 Goiter? Y N P
 Difficulty swallowing? Y N P
 Pain or stiffness in neck? Y N P

RESPIRATORY CONTINUED

Coughing up blood? Y N P
 Pneumonia? Y N P
 Pleurisy? Y N P
 Difficulty breathing? Y N P
 Shortness of breath? Y N P
 “ “ when lying? Y N P
 Pain on breathing? Y N P
 Emphysema? Y N P
 Tuberculosis? Y N P

IMMUNE

Reactions to immunizations? Y N P
 Chronically swollen glands? Y N P
 Slow wound healing? Y N P
 Chronic fatigue syndrome? Y N P
 Chronic infections? Y N P
 Night sweats? Y N P

CARDIOVASCULAR

Heart disease? Y N P
 Angina? Y N P
 High/Low blood pressure? Y N P
 Heart murmur? Y N P
 Blood clots? Y N P
 Fainting? Y N P
 Phlebitis? Y N P
 Palpitations/fluttering heart? Y N P
 Chest pain? Y N P
 Rheumatic fever? Y N P
 Swelling in ankles? Y N P

GASTROINTESTINAL

Trouble swallowing? Y N P
 Change in thirst? Y N P
 Change in appetite? Y N P
 Nausea/vomiting? Y N P
 Ulcer? Y N P
 Jaundice? Y N P
 Gall bladder disease? Y N P
 Liver disease? Y N P
 Hemorrhoids? Y N P
 Pancreatitis? Y N P
 Heartburn? Y N P
 Abdominal pain or cramps? Y N P
 Belching or passing gas? Y N P
 Constipation? Y N P
 Bowel movments: how often? _____
 Is this a change? _____
 Black stools? Y N P
 Blood in stools? Y N P
 Anorexia/Bulimia Y N P

Juliette Soihl, ND

Renewed Health ~ 5010 NE 33rd Ave ~ Portland, OR 97211

SKIN

Rashes?	Y	N	P
Acne/boils?	Y	N	P
Change in skin color?	Y	N	P
Lumps or bumps on skin?	Y	N	P
Eczema or hives?	Y	N	P
Itching?	Y	N	P
Perpetual hair loss?	Y	N	P

URINARY

Increased freq. Of urination?	Y	N	P
Inability to hold urine?	Y	N	P
Pain on urination?	Y	N	P
Frequency at night?	Y	N	P
Frequent UTIs?	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

Anemia?	Y	N	P
Easy bleeding or bruising?	Y	N	P
Cold hands/feet?	Y	N	P
Deep leg pain?	Y	N	P
Thrombophlebitis?	Y	N	P
Varicose veins?	Y	N	P

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P
Sexual orientation: _____			
Birth control? Type: _____			
Discharge or sores?	Y	N	P
Chlamydia?	Y	N	P
Gonorrhea?	Y	N	P
Genital warts?	Y	N	P
Herpes?	Y	N	P
Syphilis?	Y	N	P
Hernias?	Y	N	P
Testicular masses?	Y	N	P
Testicular pain?	Y	N	P
Prostate disease?	Y	N	P
Impotence?	Y	N	P
Premature ejaculation?	Y	N	P

FEMALE REPRODUCTIVE

Age of first menses: _____			
Age of last menses (if menopausal): _____			
Length of cycle: _____ days			
Duration of menses: _____ days			
Are your cycles regular?	Y	N	P
Painful menses?	Y	N	P
Heavy or excessive flow?	Y	N	P
PMS?	Y	N	P
Symptoms: _____			

Bleeding between cycles?	Y	N	P
Clotting?	Y	N	P
Endometriosis?	Y	N	P
Ovarian cysts?	Y	N	P
Vaginal odor?	Y	N	P
Vaginal discharge?	Y	N	P
Date of last pap smear: _____			
Abnormal PAP?	Y	N	P
Cervical dysplasia?	Y	N	P
Are you sexually active?	Y	N	P
Sexual orientation: _____			
Birth control? Type: _____			
Pain during intercourse?	Y	N	P
Gonorrhea?	Y	N	P
Herpes?	Y	N	P
Chlamydia?	Y	N	P
Genital warts?	Y	N	P
Syphilis?	Y	N	P
Difficulty conceiving?	Y	N	P
Number of pregnancies: _____			
Number of live births: _____			
Number of miscarriages: _____			
Number of abortions: _____			
Do you do self breast exams?	Y	N	P
Breast pain/tenderness?	Y	N	P
Breast lumps?	Y	N	P
Nipple discharge?	Y	N	P
Menopausal symptoms?	Y	N	P

MENTAL/EMOTIONAL

Treated for emotional prob?	Y	N	P
Depression?	Y	N	P
Anxiety or nervousness?	Y	N	P
Poor concentration?	Y	N	P
Do you have mood swings?	Y	N	P
Considered suicide?	Y	N	P
Tension?	Y	N	P
Memory problems?	Y	N	P

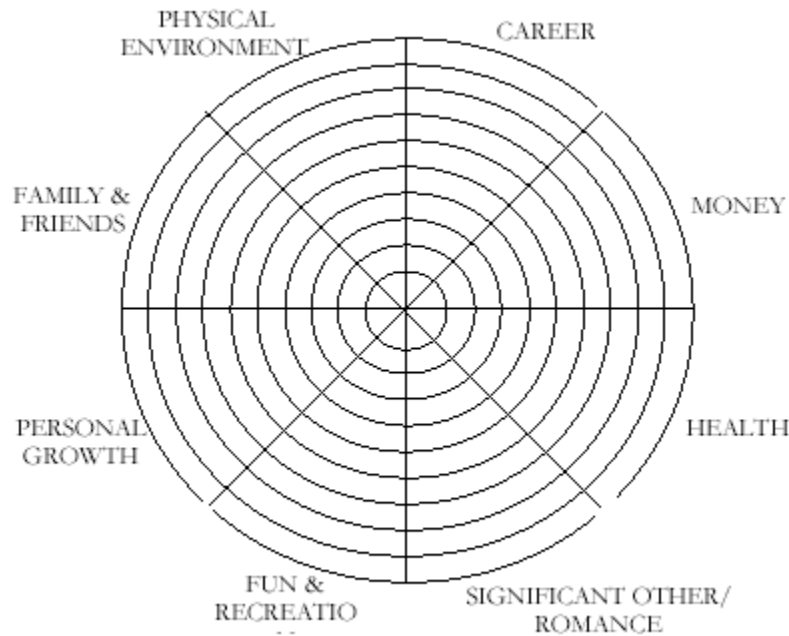
How did you hear about me? ()From a Friend ()Yellow Pages ()Website ()Insurance Company
()Practitioner/Other Referral ()Flyer/Business Card ()Other _____

Juliette Soihl, ND

Renewed Health ~ 5010 NE 33rd Ave ~ Portland, OR 97211

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 60% satisfied in your career, shade the first six levels of the career slice. Do the same for each area, starting from the center point radiating outward.



Thank you for your time and effort. I look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so at the bottom of this page.