

Dr. Deborah Nixdorf, ND, LAc
Naturopathic & Classical Chinese Medicine
Northwest Health & Healing Center

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home): _____ (work): _____

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: _____

Employer Name & Address: _____

How did you hear about Dr. Nixdorf? _____

If Internet: OANP website: ___ Google: ___ Other: ___

Has any other family member already been a patient of Dr. Nixdorf? _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Address: _____

Insurance? No / Yes Insurance Name: _____ Phone # _____

Policy/ID Number: _____ Group Number: _____

I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers. I am responsible for all charges of all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

Signature: _____ Date: _____

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.

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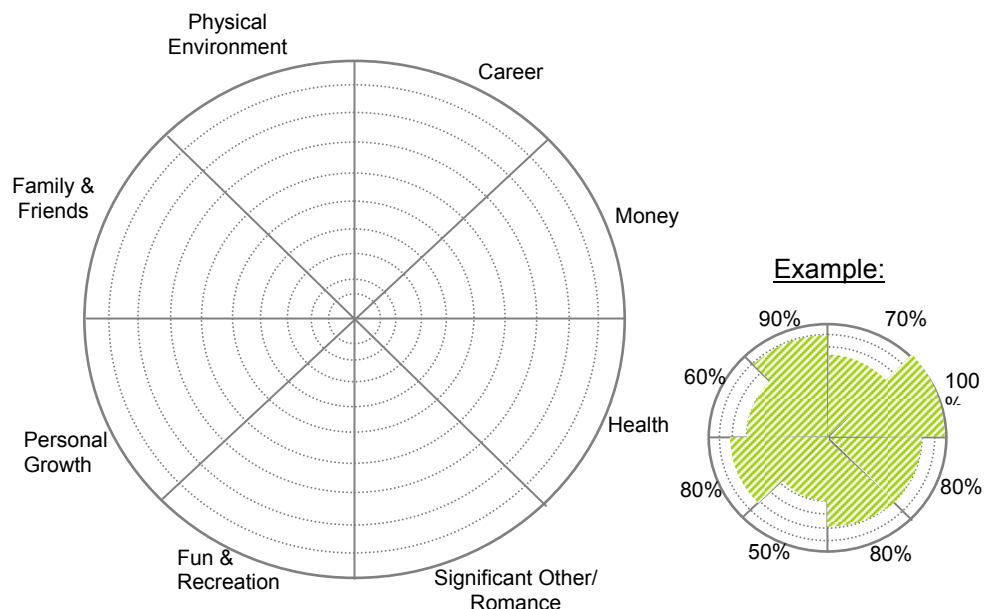
- Why did you choose to come to see Dr. Nixdorf?
- What do you know about Dr. Nixdorf's approach?
- What *three* expectations do you have from *this* visit?
- What *long term* expectations do you have of me personally as your physician?
- What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)
 0% 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 are self destructive?
- 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?
- Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?
- What do you love to do?

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 50% satisfied in your career, shade the center ½ of the career slice.

Do the same for each area, starting from the center point radiating outwards.



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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) _____

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 & say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hayfever	Hives	Celiac

Any other relevant family history? _____

What is your heritage: _____

Childhood Illnesses

Please circle whether you had any of these as a child:

Rheumatic fever	Scarlet fever	Diphtheria	Chicken Pox
German measles	Mumps	Measles	

Other: _____

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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 any of the following? (please circle)

Laxatives	Appetite suppressants	Antacids	Cortisone
Antibiotics	Thyroid medication	Tranquilizers	Sleeping Pills
Birth Control	Hormone Replacement	Blood Thinners	Pain relievers

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

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

General

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

Maximum Weight : _____ When: _____

When during the day is your energy the best? _____

Worst? _____

Main interest and hobbies: _____

Exercise: Y / N If so, what kind & 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: _____

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FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N**=Never had **P**=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
Do you eat out often?	Y	N	P
Do you drink coffee?	Y	N	P
Drink black/green tea?	Y	N	P
Do you drink soda?	Y	N	P
Do you eat refined sugar?	Y	N	P
Do you add salt to your food?	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

Eyes

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

Endocrine

Hypothyroid?	Y	N	P
Hyperthyroid?	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
Difficulty exercising?	Y	N	P

Immune

Reactions to immunizations?	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
Night Sweats?	Y	N	P

Ears

Impaired hearing?	Y	N	P
Ringing in ears?	Y	N	P
Earaches?	Y	N	P
Dizziness?	Y	N	P

Nose and Sinuses

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

Mouth and Throat

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

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Respiratory

Cough?	Y	N	P
Sputum?	Y	N	P
Coughing 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
'' '' when lying down?	Y	N	P
Tuberculosis?	Y	N	P

Head

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

Neck

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

Mental / Emotional

Treated for emotional problems?	Y	N	P
Depression?	Y	N	P
Do you have 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

Musculoskeletal

Joint pain or stiffness?	Y	N	P
Arthritis?	Y	N	P
Broken bones?	Y	N	P
Swelling in ankles?	Y	N	P
Muscle spasms or cramps?	Y	N	P
Sciatica?	Y	N	P
Weakness?	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 heart?	Y	N	P
Rheumatic Fever?	Y	N	P
Chest pain?	Y	N	P

Skin

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

Gastrointestinal

Trouble swallowing?	Y	N	P
Change in appetite?	Y	N	P
Change in thirst?	Y	N	P
Belching or passing gas?	Y	N	P
Nausea or vomiting?	Y	N	P
Abdominal pain or cramps?	Y	N	P
Ulcer?	Y	N	P
Heartburn?	Y	N	P
Constipation?	Y	N	P
Diarrhea?	Y	N	P
Bowel Movements: how often?	Y	N	P
Is this a change?	Y	N	P
Black stools?	Y	N	P
Hemorrhoids?	Y	N	P
Blood in stool?	Y	N	P
Jaundice (yellow skin)?	Y	N	P
Liver Disease?	Y	N	P
Pancreatitis?	Y	N	P

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Blood

Anemia? Y N P
Easy bleeding of 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

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 urinary infections? Y N P
Kidney stones? Y N P

Male Reproduction

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

Female Reproduction / Breasts

Age of first menses? _____
Age of last menses? (if menopausal) _____
Are cycles regular? Y N P
Length of cycle? _____ days
Duration of menses? _____ days
Painful menses? Y N P
Heavy or excessive flow? Y N P
Clotting? Y N P
Bleeding between cycles? Y N P
PMS? Y N P
If yes, what are your symptoms?

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
Endometriosis? Y N P
Ovarian cysts? Y N P
Are you sexually active? Y N P
Sexual difficulties? Y N P
Sexual orientation: _____
Pain during intercourse? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Genital Warts? Y N P
Herpes? Y N P
Syphilis? Y N P
Do you do breast self exams? Y N P
Breast pain/tenderness? Y N P
Birth control? Type: _____
Difficulty conceiving? Y N P
Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____
Breast lumps? Y N P
Nipple discharge? Y N P
Menopausal symptoms? Y N P

Thank you for your time and effort. We 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 on the back of this page.