

**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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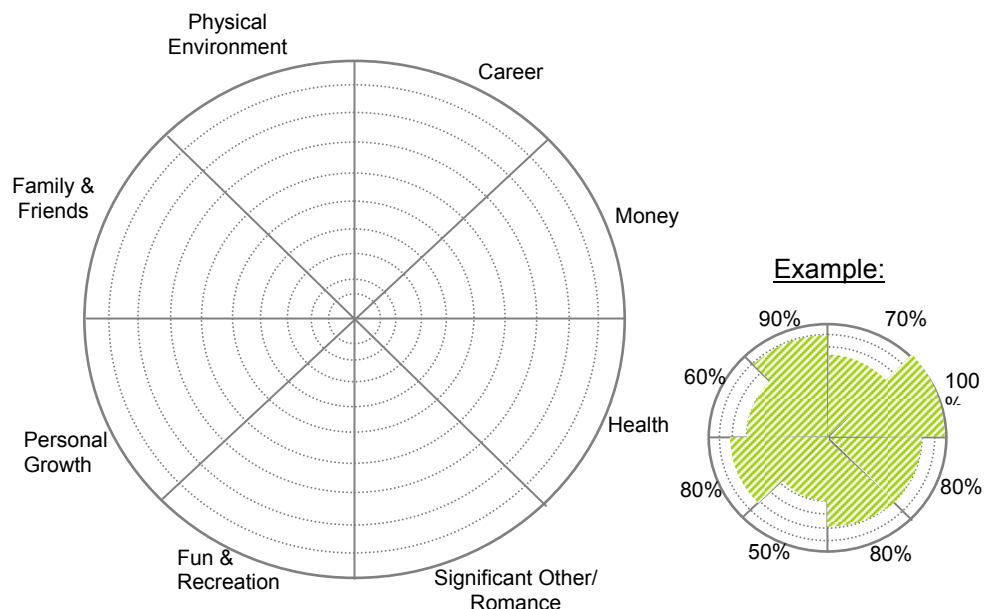
- Why did you choose to come to see Dr. Nixdorf?
- What do you know about Dr. Nixdorf's approach?
- What *three* expectations do you have from *this* visit?
- What *long term* expectations do you have of me personally as your physician?
- What is your present level of commitment to address any underlying 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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**Y**=a condition you have now    **N**=Never had    **P**=Significant problem in the past

**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.