**Awaken Natural Medicine**

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Awakennaturalmedicine.com

503-422-6913

**Patient Information:**

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

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Married: \_\_\_\_ Divorced: \_\_\_\_ Widowed: \_\_\_\_ Single: \_\_\_\_ Partnership: \_\_\_\_

Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired: \_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information:**

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Other Information:**

Have you been to see a naturopath before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about the clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of another physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, Who? Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the phone number of the physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Care**

I have read the above information and certify it to be true and correct and to the best of my knowledge. I hereby authorize this clinic to provide me with naturopathic care in accordance with the states’ statutes.

Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Health History**

Why did you choose our clinic?

What expectations or primary concerns do you have from this visit to our clinic today?

What long term concerns do you have and want address at this clinic?

When and where did you receive your last health exam?

Do you have any known health conditions? If yes, please list.

Have you been hospitalized or had any X-rays, CAT scans, EEG’s or EKG’s in the last 10 years? If yes, for what reason and when?

Have you been traveling recently? If yes, where?

Please list all supplements/herbs/homeopathics/vitamins you are currently taking or have taken in the last year.

Please list all medications including over-the-counter medications you are currently taking or have taken in the past. If taking over-the-counter medications, please list how often you take them.

Do you have any drug allergies? If yes, please list.

Do you have any food, chemical or environmental allergies? If yes, please list.

**Current Living Situation**

Do you have any children? If yes, please list names and age.

What is your current living situation?

Do you have any pets?

**Family History**

Family history would include mother, father, sisters, brothers and grandparents. This information could be crucial to your total health picture.

Is there any family history of any of the following conditions (please circle)?

Anemia Allergies/Hayfever Arthritis Asthma Cancer Depression

Diabetes Eczema Epilepsy Heart Disease High Blood Pressure Glaucoma

Kidney Disease Mental Illness Psoriasis Syphilis Stroke Tuberculosis

Any other relevant family history? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship Alive/Deceased Age of Death Present/Past Health Issues**

Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sisters\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandparents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childhood Illnesses**

Please circle any of the illnesses you had as a child.

Diptheria German Measles Measles Mumps Rheumatic Fever Scarlet Fever

**General**

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_lbs. Weight 1 year ago: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

Maximum Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs. When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits**

HABIT None Light Moderate Heavy

Alcohol ◻ ◻ ◻ ◻

Appetite ◻ ◻ ◻ ◻

Coffee ◻ ◻ ◻ ◻

Exercise ◻ ◻ ◻ ◻

Salty Foods ◻ ◻ ◻ ◻

Sleep ◻ ◻ ◻ ◻

Soda ◻ ◻ ◻ ◻

Sugar ◻ ◻ ◻ ◻

Tobacco ◻ ◻ ◻ ◻

Water ◻ ◻ ◻ ◻

What kind of exercise do you do and how often?

How many hours of sleep do you get at night? Do you wake feeling refreshed?

Do you have any hobbies or interests?

Do you enjoy your work?

Do you take time for yourself? How often?

Take vacations?

Spend time outdoors?

Watch television?

Read?

Do you have a history of abuse?

Do you have a history of trauma?

Do you have a support system/relationships?

Have you ever been treated for drug or alcohol dependence? If yes, please explain.

**Diet**

List your typical daily food intake

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beverages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

**Y**=You have now **N**=Never had **P**=Problem in past

**Mental/Emotional**

Treated for emotional problems Y N P Mood swings Y N P

Anxiety/nervousness Y N P Poor concentration Y N P

Depression Y N P Suicidal thoughts/attempts Y N P

Memory problems Y N P Tension Y N P

**Head**

Headaches Y N P Head Injuries Y N P

Migraines Y N P TMJ/Jaw problems Y N P

**Neck**

Lumps Y N P Swollen glands Y N P

Goiters Y N P Pain/stiffness Y N P

**Eyes/Ears/Nose/Throat**

Glasses Y N P Contacts Y N P

If yes, Near or Far sighted

Cataracts Y N P Glaucoma Y N P

Eye pain/strain Y N P Blurred vision Y N P

Tearing/Dryness Y N P Spots in eyes Y N P

Colorblindness Y N P Double vision Y N P

Impaired hearing Y N P Ringing /Noise Y N P

Earache Y N P Ear discharge Y N P

Fullness in ears Y N P

Frequent colds Y N P Stuffiness Y N P

Nose bleeds Y N P Loss of smell Y N P

Hayfever Y N P Sinus problems Y N P

Frequent sore throats Y N P Excess/Copious saliva Y N P

Sore tongue/lips Y N P Hoarseness Y N P

Teeth grinding Y N P Dental cavities Y N P

Gum problems/bleeding Y N P Jaw clicking/pain Y N P

Tonsillitis Y N P

**Respiratory**

Asthma Y N P Cough-chronic Y N P

Spitting up blood Y N P Wheezing Y N P

Sputum Y N P Bronchitis Y N P

Pneumonia Y N P Pleurisy Y N P

Emphysema Y N P Difficulty breathing Y N P

Chest pain Y N P Shortness of breath Y N P

Tuberculosis Y N P \*when lying down Y N P

**Generals**

Chills Y N P Fatigue Y N P

Fever Y N P Loss of sleep Y N P

Weight loss Y N P Night sweats Y N P

Mental cloudiness Y N P Excess sweating Y N P

**Cardiovascular**

Heart disease Y N P Angina Y N P

High blood pressure Y N P Low blood pressure Y N P

Murmurs Y N P Blood clots Y N P

Fainting Y N P Phlebitis Y N P

Palpitations/Flutter Y N P Rheumatic Fever Y N P

Chest pain Y N P Swelling of ankles Y N P

Rapid heartbeat Y N P Slow heartbeat Y N P

Poor circulation Y N P Hardening of arteries Y N P

**Gastrointestinal**

Trouble swallowing Y N P Belching Y N P

Heartburn Y N P Gas Y N P

Constipation Y N P Diarrhea Y N P

Difficult digesting Y N P Abdominal pain/cramps Y N P

Bloating Y N P Ulcer Y N P

Hemorrhoids Y N P Gall bladder disease Y N P

Jaundice Y N P Liver problems Y N P

Nausea Y N P Vomiting Y N P

Excessive hunger Y N P \*blood Y N P

Empty feeling Y N P Poor appetite Y N P

Bowel movements, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have they changed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Black stools? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood in stool? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urinary**

Pain on urination Y N P Increased frequency Y N P

Bed wetting Y N P Frequent infections Y N P

Inability to hold urine Y N P Kidney disease Y N P

Kidney stones Y N P Blood in urine Y N P

Pus in urine Y N P Waking to urinate Y N P

\*How often\_\_\_\_\_\_\_\_\_\_\_

**Skin**

Hives Y N P Acne Y N P

Boils Y N P Itching Y N P

Hair loss Y N P Discoloration Y N P

Rashes Y N P Eczema Y N P

Lumps Y N P Abnormal moles Y N P

Nail fungus Y N P

**Neurologic**

Seizures Y N P Paralysis Y N P

Muscle weakness Y N P Numbness/Tingling Y N P

Loss of memory Y N P Vertigo/Dizziness Y N P

Loss of balance Y N P Tremors Y N P

**Endocrine**

Heat or cold intolerance Y N P Diabetes Y N P

Hypothyroidism Y N P Hypoglycemia Y N P

Excessive thirst Y N P Excessive hunger Y N P

**Musculoskeletal**

Arthritis Y N P Bursitis Y N P

Joint pain/stiffness Y N P Broken bones Y N P

Weakness Y N P Sciatica Y N P

Muscle spasms/cramps Y N P Low back pain Y N P

Shoulder pain Y N P Hernia Y N P

Neck pain Y N P

**Blood/Peripheral Vascular**

Bruise easily Y N P Varicose veins Y N P

Easy bleeding Y N P Anemia Y N P

Deep leg pain Y N P Cold hands/feet Y N P

Thrombophlebitis Y N P

**Immune system**

Vaccine reactions Y N P Chronic infections Y N P

Chronic swollen glands Y N P Chronic Fatigue Syndrome Y N P

**Male Reproductive**

Hernias Y N P Testicular masses Y N P

Testicular pain Y N P Prostate disease Y N P

Discharge/sores Y N P Venereal disease Y N P

Chlamydia Y N P Gonorrhea Y N P

Condyloma Y N P Herpes Y N P

Syphilis Y N P Impotence Y N P

Are you sexually active \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Premature ejaculation Y N P

Sexual orientation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth control? If yes, what type. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female Reproductive**

Age of first menses \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of last menses \_\_\_\_\_\_\_\_\_\_\_\_\_

Length of cycle \_\_\_\_\_\_\_\_\_\_\_\_\_days Duration of menses \_\_\_\_\_\_\_\_\_\_days

Painful menses Y N P Heavy or excessive flow Y N P

PMS? Y N P Are your cycles regular Y N P

If yes, what are your symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopausal symptoms Y N P

If yes, what are your symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding between cycles Y N P Pain during intercourse Y N P

Clotting Y N P Discharge Y N P

Are you sexually active Y N P Sexual orientation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Control Y N P

If yes, what type of birth control \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of live births \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of abortions \_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of abnormal PAP Y N P Endometriosis Y N P

Ovarian cycsts Y N P Difficulty conceiving Y N P

Cervical dysplasia Y N P Sexual difficulties Y N P

Gonorrhea Y N P Chlamydia Y N P

Herpes Y N P Condyloma Y N P

Syphilis Y N P Breast pain/tenderness Y N P

Breast lumps Y N P Nipple discharge Y N P

Do you do self breast exams Y N P

What is your level of commitment to improving your health? (Rate from 0-100%)

Are there any obstacles that could get in the way of improving your health?

Do you have someone to support you in your lifestyle changes? If yes, who will that be?

Is there any other information that you think would be relevant to your health and healing that you would like to share with the doctor?