Dr. Keri Marshall

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PERSONAL INFORMATION:

Name_____Date_____
Address_____
City_____ State_____ Zip_____
Telephone (home)_____(work)_____
E-mail_____ Date of Birth_____
Age_____ Gender Female____Male_____
Relationship Status Single____Married_____Divorced_____Widowed_____
Occupation_____Hours per week_____Employer_____
In case of emergency, please notify_____
Relationship_____Phone_____

HEALTH OVERVIEW

Name of current general practitioner_____

Do you have any known contagious disease at this time? Y N If yes, what?_____
What is the main reason for your visit today? _____
_____

What are your most important health concerns, in order of importance?

1. _____
2. _____
3. _____
4. _____
5. _____

How did you hear about our clinic?_____

Would you like to be informed by email of upcoming classes and events at our clinic?
Yes_____ No_____

Cancellation Policy:

I understand that I am responsible for paying the full cost of treatment if I do not give 24 hour notice of change or cancellation.

Consent:

I hereby consent to receive treatment by the practitioners at Makai Naturopathic Center. I understand that this consent is voluntary and may be revoked by me at any time. I understand the fee structure, and accept responsibility for payment.

Signature_____Date_____

HEALTH HISTORY QUESTIONAIRRE

FAMILY HISTORY

Do you have a family history of any of the following (Please Circle)?

Cancer	Diabetes	Heart Disease
Kidney Disease	Epilepsy	High Blood Pressure
Tuberculosis	Stroke	High Cholesterol
Asthma/Hayfever/Hives	Arthritis	Anemia

Any other relevant family history? _____

_____

What is your ethnic heritage?_____

CHILDHOOD ILLNESSES

Scarlet Fever	Diphtheria	Rheumatic Fever
Mumps	Measles	German Measles

IMMUNIZATIONS

Please place a check next to all that apply.

	Polio		Pertussis
	Tetanus: When?_____		Diphtheria
	Measles/Mumps/Rubella		Travel Related:

HOSPITALIZATIONS, SURGERIES & IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKG's have you had?

_____year:_____ _____year:_____
_____year:_____ _____year:_____
_____year:_____ _____year:_____
_____year:_____ _____year:_____

ALLERGIES & SENSITIVITIES

Are you allergic or hypersensitive to:
Medications:_____
Foods:_____
Environmental or chemical agents:_____

CURRENT MEDICATIONS

Do you take or use (Please circle)?

Laxatives	Pain relievers	Antacids
Cortisone	Appetite suppressants	Antibiotics
Tranquilizers	Thyroid medication	Sleeping pills

Please list any prescription medications, over the counter medications, vitamins or supplements you are taking.

1)_____ 5)_____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8)_____

GENERAL HEALTH

Height_____ Weight _____lbs. Weight 1 year ago _____lbs.
Max. weight _____lbs. Min. Adult weight _____lbs. When_____
When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS

Please check any of the following conditions you currently have (C box), have had in the past (P box), or have never had (N box). Please also check if you feel any of the following are a significant part of your medical history.

LIFESTYLE

C	P	N		C	P	N	
			Alcohol				History of smoking
			Marijuana				How many packs/day?
			Drugs				How many years?
			Treated for drug dependence				Occupational hazards
			Stress				Any major traumas

MENTAL/EMOTIONAL

C	P	N		C	P	N	
			Treated for emotional problems				Depression
			Mood swings				Anxiety or nervousness
			Considered/attempted suicide				Tension
			Poor concentration				Memory problems

ENDOCRINE

C	P	N		C	P	N	
			Hypothyroid				Heat or cold intolerance
			Hyperthyroid				Diabetes
			Hypoglycemia				Excessive hunger
			Excessive thirst				Fatigue
			Seasonal depression				

IMMUNE

C	P	N		C	P	N	
			Chronic fatigue syndrome				Chronic infections
			Chronically swollen glands				Slow wound healing
			Reactions to vaccines				Reactions to immunizations

NEUROLOGIC

C	P	N		C	P	N	
			Seizures				Heat or cold intolerance
			Muscle weakness				Numb/Tingling extremities
			Tremor				Loss of memory
			Vertigo or dizziness				Difficulty concentrating

SKIN

C	P	N		C	P	N	
			Rashes				Eczema, hives
			Acne, boils				Itching
			Color change				Perpetual hair loss
			Lumps				Night sweats

HEAD

C	P	N		C	P	N	
			Headaches				Head injury
			Migraines				Jaw/TMJ problems

EARS

C	P	N		C	P	N	
			Impaired hearing				Ringing in the ears/ Tinnitus
			Earaches				Dizziness

EYES

C	P	N		C	P	N	
			Spots in eyes				Cataracts
			Impaired vision				Glasses or contacts
			Blurriness				Eye strain/pain
			Color blindness				Tearing or dryness
			Double vision				Glaucoma

NOSE & SINUSES

C	P	N		C	P	N	
			Frequent colds				Nose bleeds
			Stuffiness or post-nasal drip				Hayfever
			Sinus problems				Loss of smell

MOUTH & THROAT

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

NECK

C	P	N		C	P	N	
			Lumps				Swollen glands
			Goiter				Pain or stiffness

RESPIRATORY

C	P	N		C	P	N	
			Cough				Sputum
			Spitting up blood				Wheezing
			Asthma				Bronchitis
			Pneumonia				Pleurisy
			Emphysema				Difficulty breathing
			Pain on breathing				Shortness of breath
			Shortness of breath at night				Shortness of breath lying down

CARDIOVASCULAR

C	P	N		C	P	N	
			Heart disease				Angina
			High/low blood pressure				Murmurs
			Blood clots				Fainting
			Phlebitis				Palpitations/Fluttering
			Rheumatic fever				Chest pain
			Swelling in ankles				High cholesterol

GASTROINTESTINAL

C	P	N		C	P	N	
			Trouble swallowing				Constipation
			Reflux				Diarrhea
			Heartburn				Blood with stool
			Vomiting blood				Change in bowel movements
			Nausea				Abdominal pain or cramps
			Change in appetite				Gallbladder disease
			Vomiting				Black stools
			Belching or passing gas				Colon polyps
			Ulcer				Jaundice
			Hemorrhoids				Liver disease

URINARY

C	P	N		C	P	N	
			Pain on urination				Frequency at night
			Increased frequency				Inability to hold urine/urgency
			Frequent infections				Kidney stones

MUSCULOSKELETAL

C	P	N		C	P	N	
			Joint pain or stiffness				Arthritis
			Broken bones				Weakness
			Muscle spasms or cramps				Sciatica

BLOOD/PERIPHERAL VASCULAR

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

FEMALE REPRODUCTION/BREASTS

Age of first menses_____ Length of cycle_____
Duration of menses_____ Age of last menses (menopausal)_____
Date of last annual exam/PAP (M/D/Y)_____

C	P	N		C	P	N	
			Irregular cycles				Abnormal PAP
			Bleeding between cycles				Cervical dysplasia
			Cramping with menses				Endometriosis
			Premenstrual syndrome				Ovarian cysts
			Clotting				Uterine fibroids
			Heavy or excessive flow				Sexually active
			Vaginal discharge				Painful intercourse
			Menopausal symptoms				Sexual difficulties
			Breast lumps				Sexually transmitted disease
			Breast pain/tenderness				Birth control: type_____
			Nipple discharge				Difficulty conceiving

Number of pregnancies_____ Number of live births_____
Number of miscarriages_____ Number of abortions _____
Do you do a self-breast exam? Y N Hysterectomy? Y N

MALE REPRODUCTION

C	P	N	
			Hernias
			Testicular masses
			Testicular pain
			Prostate disease
			Sexually active

C	P	N	
			Sexually transmitted disease
			Discharge or sores
			Impotence
			Premature ejaculation
			Birth Control: type