Krista Anderson Ross, ND

Heartspace Center for Healing

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Name:_____Today's date: _____

Date of Birth:_____Email:_____

Address:_____

Home Phone:_____Day Phone:_____

Is any discretion necessary when contacting you via telephone or email for appointment reminders or general communications?_____

Occupation:_____Hours worked per week :_____

Age:_____ Gender: female_____ male_____

Emergency Contact :_____Relationship to patient:_____

Home Phone:_____Cell Phone:_____

How did you hear about our clinic?_____

Where and when did you last receive medical care? What was the reason?

_____

Date of last physical exam?_____Dental Exam?_____

What brings you into the office today?

What expectations do you have from this visit to our clinic?

What are your top health concerns in order of importance:

My general state of health has been:

Excellent ____ Good_____ Fair_____ Poor____

List any medications, over the counter drugs, vitamins or other supplements that you are taking. Feel free to write on back or use additional page if needed:

List any allergies to drugs, supplements, or chemicals:

Do you have any known intolerances to certain foods:

List any medical problems that you have had in the past. Have you ever been hospitalized or had surgery? If so when and what for?

Please circle any symptoms you have experienced in the past two years:

Difficulty Concentrating
Increased Forgetfulness
Foggy Thinking
Tearful
Depressed
Mood Swings
Fluid Retention/Bloating
Incontinence
Hot Flashes
Night Sweats
Acne
Scalp Hair Loss
Weight Gain in Hips
Weight Gain in Waist
High Cholesterol
Elevated Triglycerides
Constipation
Cold Body Temp (less than 98.6)
Goiter
Hoarseness
Slow Pulse Rate
Rapid Heartbeat or Palpitations

Family Medical History:

Please note the diseases that each of the following members of your family has or had. If they are deceased please note the age at which they died and the cause of their death.

Mother:

Father:

Paternal Grandmother:

Paternal Grandfather:

Maternal Grandfather:

Maternal Grandmother:

Siblings:

Diet:
Please give examples of typical foods that you might eat for each meal.

Breakfast

Snack

Lunch

Snack

Dinner

Number of alcoholic beverages consumed per week?_____

Do you or have you ever smoked or used illegal drugs? If yes when and for how long?

Sleep:

Hours slept at night? Do you wake rested?

Exercise:

Hours spent in physical activity per week?

Types of exercise?

Toxicity Exposure

Number of fillings and crowns? How many are mercury (silver)?

Hobbies?

Have you ever lived near or worked in agriculture, or major industry?

Any known toxic exposures?