

Primavita Family Medicine, PLLC

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Welcome to our clinic! Please answer all questions as thoroughly as possible to assist Dr. Shinsato in providing you the best care possible. This form is confidential and the information will not be released to anyone outside this clinic without your written permission.

Please mail or fax this form to us 2-3 days before your visit so Dr. Shinsato may review your health profile. Otherwise, please bring the completed form with you to your visit. If you have any questions, please make a note and ask Dr. Shinsato for clarification during your visit.

If you have a good experience with our clinic, please tell others! If you did not have a good experience with us, please tell us, we appreciate your feedback to help us serve you better. Thank you for your assistance!

ADULT HEALTH PROFILE

Today's Date: _____

Name: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

E-mail Address: _____

May we leave messages on your phone relating to your visits? Y N

May we send you clinical information? Y N

Date of birth: _____ Age: _____ Blood Type: _____ Ht: _____ Wt: _____

Are you pregnant, planning or lactating? _____ Ethnicity: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us: _____

Current Health Care Provider(s):	Type	Phone	Fax

Primary Health Concerns: Please prioritize 1 or 2 health concerns that you would like to address during your first appointment.	Prior Diagnoses	Prior Labs/Imaging	Prior Treatments

Note: If there is an extensive history associated with your health concern(s), please attach a separate piece of paper with a timeline of events, including symptoms, diagnoses, lab tests, treatments, what has helped and what has not helped.

Please list other symptoms or concerns that you have:

How did these conditions develop? Can you identify any traumatic events that may have caused or aggravated your health problems? What happened in your life around this time?

Have you ever consulted: Naturopathic Physicians Acupuncturists Chiropractors Nutritionists Other _____

What level of change to your living habits are you willing to make to improve your health and address underlying causes of your signs and symptoms? (0% being no commitment, 100% complete commitment)

0% 10 20 30 40 50 60 70 80 90 100%

What goals do you have for your visit today?

What long-term expectations do you have for working with Primavita?

MEDICAL HISTORY

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with appropriate dates:

MEDICATIONS:

Do you take or use the following?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisol	Y N	Antibiotics	Y N	Appetite suppressants	Y N
Tranquilizers	Y N	Thyroid medications	Y N	Sleeping aids	Y N
Aspirin	Y N	Birth Control	Y N		

Type? _____

List all the drugs (prescription and over the counter pharmaceuticals) including dosages.

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Are you sensitive/allergic to any drugs, foods, chemicals, animals, environmental substances? Y N

If yes, please list: _____

What happens when you have an "allergy attack"? _____

What prior types of allergy testing have you had? _____

CURRENT SUPPLEMENTS:

List all vitamins, minerals, herbs, homeopathics, with dosages:

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Over the last 2 years, how many times have you been treated with antibiotics, for what condition? _____

PAST MEDICAL HISTORY

Your Prenatal/birth/feeding history:

Describe your mother's pregnancy with you: Natural Forceps Epidural C-section Trauma

Breast fed? _____ how long? _____ Formula (kind): _____ how long? _____

What childhood illnesses have you had?

- Rubella (German 3 day measles) Measles (2 week) Mumps Chickenpox
- Whooping Cough Rheumatic Fever Polio Scarlet Fever
- Roseola Asthma Thrush Epilepsy
- Mononucleosis Strep Throat Ear infections Colic
- Rashes/cradle cap Constipation Jaundice Headaches

Immunizations: Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria
 Hepatitis B chicken pox H. influenzae Flu shot Other (for travel) _____

Major Illnesses/emotional or physical trauma/ accidents (not already listed):

Type	Date	Treatment Received	Outcome

Outpatient Procedures / Hospitalizations, surgeries/ special diagnostic studies:

Type of surgery/study	Date	Reason for procedure	Outcome/Results

Recent physical exam: Date: _____ Results: _____ normal

Recent blood work/ urine test: Date: _____ Results: _____ normal

Recent PAP/ pelvic or prostate exam: Date: _____ Results: _____ normal

Recent mammogram (females over 40): Date: _____ Results: _____ normal

LIFESTYLE

Are you currently: Single Married Partnership Separated Divorced Widowed
Live with: Spouse Partner Parents Children Friends Alone
Are you sexually active? (circle one) Yes No If yes, is it with (circle one): male female both
Do you or your partner(s) use any form of contraception? Yes No If so, what type(s)? _____
Are you pregnant? Yes No Trying to get pregnant? Yes No If so, how far along? _____
Do you have children? Yes No How many? _____ Names/ ages/ and health or wellness issues: _____

How would you describe your general health? _____
Are you happy in your job or career? Yes No _____
What personal goals do you have? _____
What makes you happy? _____
What are you grateful for? _____
What is your individual & unique purpose in this life? _____
Religious/spiritual affiliation _____
What would you like to change most about your life? _____

What behaviors, habits, or thoughts would you like to eliminate? _____

Is your present sex life satisfactory? _____
Do you drink alcohol? Yes No How often?: wine _____ beer _____ other alcohol _____
Do you use tobacco or have you in the past? No Yes, How long? _____ how much daily? _____
Do you now or have you in the past used recreational drugs? Yes No _____
Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins? Yes No
If yes, please explain _____

Do you exercise? Yes No What form(s)? _____
How often? _____
Do you make time for rest, relaxation or meditation during the day and/or before bed? Yes No
How often? _____ How do you relax? _____
What are your interests or hobbies? _____
Which of the following do you do regularly: Jogging Swimming Walking Biking Gardening
Yoga Breathing Exercises Meditation Weightlifting Pilates Pray
Other activities: _____
Do you use regularly? Chemical hair treatments Electric blanket Heating pad
Cosmetics perfumes pesticides around the home Dry cleaning Computer
Are your home and/or work environments well ventilated? Yes No Mold? Yes No
Are there unusual/unpleasant smells in your work/living environment? Yes No
When were the ducts in your home last cleaned? _____

DIET

How many meals do you generally eat each day? One Two Three More than three
Do you: eat out often diet frequently skip meals frequently
Do you have any special diet or eating restrictions? Yes No if yes, please explain _____

List the primary foods you include in your diet? _____
List the foods you exclude from your diet _____
Mark which of these you consume regularly Coffee Caffeinated teas Artificial sweeteners
Processed foods Preservatives Refined foods Margarine Fast Food Soda
List any other foods you eat which you suspect may be harmful to your health _____
List any foods you crave, regardless of their nutritional value (include sweets, chocolate, bread, salty, _____

- | | | | | | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cold application | <input type="checkbox"/> | <input type="checkbox"/> | Warm application |
| <input type="checkbox"/> | <input type="checkbox"/> | Bath | <input type="checkbox"/> | <input type="checkbox"/> | Before menstruation |
| <input type="checkbox"/> | <input type="checkbox"/> | During menstruation | <input type="checkbox"/> | <input type="checkbox"/> | After menstruation |

Other things that make you significantly better or worse: _____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you now have, N = Never had, P = a condition you have had in the past

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y	P	N	Depression?	Y	P	N
Mood Swings?	Y	P	N	Anxiety or nervousness?	Y	P	N
Considered/Attempted suicide?	Y	P	N	Tension?	Y	P	N
Poor concentration?	Y	P	N	Memory problems?	Y	P	N
Do you have concerns with abuse / violence in your life?					Y	P	N

SKIN

Rashes?	Y	P	N	Eczema, Hives?	Y	P	N
Acne, Boils?	Y	P	N	Itching?	Y	P	N
Color Change?	Y	P	N	Perpetual Hair Loss?	Y	P	N
Lumps?	Y	P	N	Night Sweats?	Y	P	N

HEAD

Headaches?	Y	P	N	Head Injury?	Y	P	N
Migraines?	Y	P	N	Jaw/TMJ problems	Y	P	N

EYES

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

EARS

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

NOSE AND SINUSES

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

MOUTH AND THROAT

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

NECK

Lumps?	Y	P	N	Swollen glands?	Y	P	N
Goiter?	Y	P	N	Pain or stiffness?	Y	P	N

RESPIRATORY

Cough?	Y	P	N	Sputum?	Y	P	N
Spitting up blood?	Y	P	N	Wheezing	Y	P	N
Asthma?	Y	P	N	Bronchitis?	Y	P	N
Pneumonia?	Y	P	N	Pleurisy?	Y	P	N
Emphysema?	Y	P	N	Difficulty breathing?	Y	P	N
Tuberculosis?	Y	P	N	Shortness of breath?	Y	P	N
Shortness of breath at night?	Y	P	N				
Shortness of breath lying down?	Y	P	N				

CARDIOVASCULAR

Heart disease?	Y	P	N	Angina?	Y	P	N
High/Low Blood Pressure?	Y	P	N	Murmurs?	Y	P	N
Blood clots?	Y	P	N	Fainting?	Y	P	N
Phlebitis?	Y	P	N	Palpitations/Fluttering?	Y	P	N
Rheumatic Fever?	Y	P	N	Chest pain?	Y	P	N
Swelling in ankles?	Y	P	N				

GASTROINTESTINAL

Trouble swallowing?	Y	P	N	Heartburn?	Y	P	N
Change in thirst?	Y	P	N	Change in appetite?	Y	P	N
Nausea?	Y	P	N	Vomiting?	Y	P	N
Vomiting blood?	Y	P	N	Bowel Movements: How often?			
Blood in stool?	Y	P	N	Is this a change?			
Pain or cramps?	Y	P	N	Constipation?	Y	P	N
Belching or passing gas?	Y	P	N	Diarrhea?	Y	P	N
Black stools?	Y	P	N	Gall Bladder disease?	Y	P	N
Jaundice (yellow skin)?	Y	P	N	Ulcer?	Y	P	N
Liver Disease?	Y	P	N	Hemorrhoids?	Y	P	N

Genitals

Chlamydia?	Y	P	N	Herpes?	Y	P	N
Gonorrhea?	Y	P	N	Syphilis?	Y	P	N
Hernias?	Y	P	N	Warts?	Y	P	N
Has anyone touched you in a way that made you uncomfortable without your permission	Y	P	N				

Male

Testicular masses?	Y	P	N	Impotence?	Y	P	N
Testicular pain?	Y	P	N	Prostate disease?	Y	P	N
Low sperm count?	Y	P	N	Premature ejaculation?	Y	P	N

Female

Age of first menses?	_____			Menopausal symptoms?	Y	P	N
Are cycles regular?	Y		N	Age of last menses?	_____		
Length of cycle?	_____days			Bleeding between cycles?	Y	P	N
Duration of menses?	_____days			Pain during intercourse?	Y	P	N
Painful menses?	Y	P	N	Clotting?	Y	P	N
Heavy or excessive flow?	Y	P	N	Discharge?	Y	P	N
PMS?	Y	P	N	Birth control?	Y	P	N
If yes, what are your symptoms?	_____			What type?	_____		
Number of pregnancies	_____			Number of live births	_____		
Endometriosis?	Y	P	N	Number of miscarriages	_____		

Ovarian cysts?	Y	P	N	Number of abortions			
Sexual difficulties?	Y	P	N	Difficulty conceiving?	Y	P	N
Cervical Dysplasia?	Y	P	N	Abnormal PAP?	Y	P	N
Do you do breast self exams?	Y	P	N	Breast lumps?	Y	P	N
Breast pain/tenderness?	Y	P	N	Nipple discharge?	Y	P	N

URINARY

Pain on urination?	Y	P	N	Increased frequency?	Y	P	N
Frequency at night?	Y	P	N	Inability to hold urine?	Y	P	N
Frequent infections?	Y	P	N	Kidney stones?	Y	P	N

ENDOCRINE

Hypothyroid?	Y	P	N	Heat or cold intolerance?	Y	P	N
Hypoglycemia?	Y	P	N	Diabetes?	Y	P	N
Excessive thirst?	Y	P	N	Excessive hunger?	Y	P	N
Fatigue?	Y	P	N	Seasonal depression?	Y	P	N

IMMUNE

Vaccinations?	Y	P	N	Reactions to vaccinations?	Y	P	N
Chronic Fatigue Syndrome?	Y	P	N	Chronic infections?	Y	P	N
Chronically swollen glands?	Y	P	N	Slow wound healing?	Y	P	N

NEUROLOGIC

Seizures?	Y	P	N	Paralysis?	Y	P	N
Muscle weakness?	Y	P	N	Numbness or tingling?	Y	P	N
Loss of memory?	Y	P	N	Easily stressed?	Y	P	N
Vertigo or dizziness?	Y	P	N	Loss of balance?	Y	P	N

MUSCULOSKELETAL

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

BLOOD/PERIPHERAL VASCULAR

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

How would you describe the emotional climate of your home? _____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

Is there anything that you feel is important that has not been covered?

Thank you for taking the time to fill out this form! It helps me to provide you with the best care possible. I look forward to working with you! -Dr. Shinsato