

**Primavita Family Medicine, PLLC**  
**Lorina Shinsato, ND**  
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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: \_\_\_\_\_

How do you prefer to be contacted?  Home  Cell  Work  Email

*Email correspondence is available for patient's for questions regarding their current treatment plan. Email is considered to be unsecured and is not recommended for the discussion of certain sensitive health related conditions. I agree to email correspondence for treatment plan clarifications and understand that it is considered unsecured. **Please Initial** \_\_\_\_\_*

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

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

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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?

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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:

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### 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, homeopathic, 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. influenza 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? \_\_\_\_\_  
 What is your current job or position? \_\_\_\_\_  
 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, sour, rich, fatty foods, etc.) \_\_\_\_\_

List any foods to which you have a bad reaction: \_\_\_\_\_

Are you thirsty often? Yes No At night? Yes No How much water do you drink daily? \_\_\_\_\_

What temperature do you prefer to drink? Hot Cold Room Temp.

Are you satisfied with your diet as it is now? Yes No If no, why not? \_\_\_\_\_

### SLEEP

Do you have trouble falling asleep? Yes No If yes, what keeps you up? \_\_\_\_\_

Do you wake at night and can't fall back to sleep? Yes No \_\_\_\_\_

Do you wake feeling refreshed? Yes No \_\_\_\_\_

Do you have recurring dreams? Yes No If yes, what is the theme? \_\_\_\_\_

### FAMILY MEDICAL HISTORY

(Please list ages and if deceased, what they passed from and at what age)

#### Mother's Side

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

Mother \_\_\_\_\_

Your Sisters \_\_\_\_\_

Your Brothers \_\_\_\_\_

#### Father's Side

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

Father \_\_\_\_\_

Has any BLOOD RELATIVE had any of the following:

Anemia

Heart Disease

Asthma/Hay Fever/Hives

Bleeding Disorder

Cancer

Diabetes

Thyroid (hyper/hypo)

Eczema

Other \_\_\_\_\_

Kidney Disease

Mental Illness

High Blood Pressure

Seizure/Epilepsy

Sickle Cell/Thalassemia

High Cholesterol

Liver Disease

Tuberculosis (TB)

Other \_\_\_\_\_

Arthritis

Autoimmune Condition

Alzheimer's

Alcoholism/Addiction

Obesity

Osteoporosis

Glaucoma

Stroke

Other \_\_\_\_\_

## GENERAL STATUS

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Ideal Weight \_\_\_\_\_  
 Weight 1 year ago \_\_\_\_\_ lbs. Max. Weight \_\_\_\_\_ When \_\_\_\_\_  
 When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

Listed below are factors which may or may not influence your state of being. Please check the appropriate box of ONLY those with SIGNIFICANT influence on your health.

BETTER	WORSE		BETTER	WORSE	
<input type="checkbox"/>	<input type="checkbox"/>	Winter	<input type="checkbox"/>	<input type="checkbox"/>	Spring
<input type="checkbox"/>	<input type="checkbox"/>	Summer	<input type="checkbox"/>	<input type="checkbox"/>	Autumn
<input type="checkbox"/>	<input type="checkbox"/>	Cold	<input type="checkbox"/>	<input type="checkbox"/>	Heat
<input type="checkbox"/>	<input type="checkbox"/>	Dampness	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Open air (being outside)	<input type="checkbox"/>	<input type="checkbox"/>	Windows closed
<input type="checkbox"/>	<input type="checkbox"/>	Change of weather	<input type="checkbox"/>	<input type="checkbox"/>	Traveling
<input type="checkbox"/>	<input type="checkbox"/>	Ocean seashore	<input type="checkbox"/>	<input type="checkbox"/>	Mountains
<input type="checkbox"/>	<input type="checkbox"/>	Physical exertion	<input type="checkbox"/>	<input type="checkbox"/>	Upon rising
<input type="checkbox"/>	<input type="checkbox"/>	Morning	<input type="checkbox"/>	<input type="checkbox"/>	Evening
<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	Hay fever?	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*