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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 bring this completed form to your First Appointment. The contents of this form is the basis of the Appointment. *If you are unable to print it, please come 30-40 minutes before your scheduled time and we will have a copy ready for you. This form takes approximately 30-40 minutes to complete, depending on your case history, so please allocate sufficient time. 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

For anyone 12 years and above

Today's Date: _____

Name: _____ Sex: M / F

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

Home Phone: _____ Cell: _____

E-mail Address: _____

How do you prefer to be contacted? ❒ Home ❒ Cell ❒ E-mail

E-mail correspondence is available for patients for questions regarding their current treatment plan. E-mail is considered to be unsecured and is not recommended for the discussion of certain sensitive health-related conditions. I agree to e-mail correspondence for treatment plan clarifications and understand that it is considered unsecured. ***Please initial:*** _____

May we leave messages on your phone relating to your visit/s? ❒ Yes ❒ *No

May we send you clinical information? ❒ Yes ❒ *No

** If you would like for communications to remain confidential i.e. to only speak to you directly – we cannot leave a message on your phone or with someone else on your behalf.*

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

Are you pregnant, planning or lactating? ❒ Yes ❒ No ❒ N/A Ethnicity: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us: _____

Current Health Care Provider's Name	Clinic Name	Type	Phone

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.

Brand & Name of Product	**Concentration** (ml/mg per unit)	**Type** (liquid, cap, tab)	**Amount Per Day**	**Why are you taking this?**	**Start date**	**Who prescribed it** (self/doctor)

Please attach another sheet if you require more space – please indicate details per above.

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"? Please provide details: _____

_____

_____

What prior types of allergy testing have you had? ❒ Skin prick ❒ IgG blood test ❒ IgE blood test ❒ Oral testing in office ❒ Other: _____

CURRENT SUPPLEMENTS:

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

Brand & Name of Product	**Concentration** (ml/mg per unit)	**Type** (liquid, cap, tab)	**Amount Per Day**	**Why are you taking this?**	**Start date**	**Who prescribed it** (self/doctor)

Please attach another sheet if you require more space – please indicate details per above.

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

_____

_____

_____

_____

PAST MEDICAL HISTORY

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

_____

Breast fed? ❒ Yes, how long? _____ ❒ No Formula (kind): _____ How long? _____

When were solids introduced? _____ months old

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 ❒ Diptheria ❒ Hepatitis B
❒ Chicken pox ❒ H. influenzae ❒ Flu shot ❒ HPV ❒Other (for travel): _____

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

Type	**Date**	**Treatment Received**	**Outcome**

If you have been in a motor vehicle collision, please ask us for a different document to complete. Further details are vital.

Outpatient procedures, hospitalizations, surgeries, special diagnostic studies:

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

Please attached another sheet if you require more space – please include details per above.

Recent physical exam: Date: _____ Results: ❒ Normal ❒ Other: _____
Recent blood work/urine test: Date: _____ Results: ❒ Normal ❒ Other: _____
Recent PAP/pelvic or prostate exam: Date: _____ Results: ❒ Normal ❒ Other: _____
Recent mammogram (females over 40): Date: _____ Results: ❒ Normal ❒ Other: _____
Recent DEXA (bone density scan): Date: _____ Results: ❒ Normal ❒ Other: _____
Recent ❒ X-ray ❒ Ultrasound ❒ MRI ❒ CT scan Date: _____ Results: ❒ Normal ❒ Other: _____

LIFESTYLE

Are you currently: ❒ Single ❒ Married ❒ Partnership ❒ Separated ❒ Divorced ❒ Widowed
Live with: ❒ Spouse ❒ Partner ❒ Parents ❒ Children ❒ Friend/s ❒ Alone
Are you sexually active? ❒ Yes ❒ No If yes, is it with: ❒ 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 If so, how many? _____
What are your kids' names, ages, and health or wellness issues: _____

_____

_____

_____

How would you describe your general health? _____

_____

_____

_____

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? ❒ Yes ❒ No
Do you drink alcohol? ❒ Yes ❒ No If so, ❒ wine ❒ beer ❒ other alcohol: _____ How often? _____
Do you use tobacco or have you in the past? ❒ Yes ❒ No If so, how long? _____ How much daily?_____
Do you now or have you in the past used recreational drugs? ❒ Yes ❒ No If so, what did you use? _____
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 If so, what form/s and 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 ❒ Reading ❒ Eating meals with family and/or friends ❒ Other: _____
Do you use regularly? ❒ Chemical hair treatments ❒ Electric blanket ❒ Heating pad ❒ Cosmetics ❒ Perfumes ❒ Computer ❒ Pesticides around the home ❒ Dry cleaning
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? _____
Have you lived near: ❒ Smelting plant ❒ Recycling plant ❒ Farming area ❒ Powerlines ❒ Other: _____
Have you worked with: ❒ Solvents (gas, chemicals, etc.) ❒ Circuitry ❒ Metals ❒ Automobiles ❒ Heavy equipment ❒ Hair coloring ❒ Pesticides/herbicides

DIET

How many meals do you generally eat each day? ❒ One ❒ Two ❒ Three ❒ More than three
When if your first meal of the day? _____ am/pm
Do you: ❒ Eat out often ❒ Diet frequently ❒ Skip meals frequently ❒ Skip breakfast
Do you have any special diet or eating restrictions? ❒ Yes ❒ No If so, ❒ dairy free ❒ gluten free ❒ paleo ❒ keto diet ❒ Other: _____

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, fatty foods, etc.*): _____

_____

List any foods to which you have a bad reaction (*please list the food and what the reaction is*): _____

_____

_____

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 temperature
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 If yes, what keeps you up? _____

_____

_____

_____

Do you wake feeling refreshed? ❒ Yes ❒ No If no, how do you feel? _____

_____

_____

_____

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		Father's Side	
Grandfather		Grandfather	
Grandmother		Grandmother	
Mother		Father	
Your Sisters			
Your brothers			

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
❒ Alzheimers
❒ Alcoholism/Addiction
❒ Obesity
❒ Osteoporosis
❒ Glaucoma
❒ Stroke
❒ Other: _____

GENERAL STATUS

Height: _____ Weight: _____ Ideal Weight: _____

Weight 1 year ago: _____ Maximum 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	
❒	❒	Winter	❒	❒	Spring
❒	❒	Summer	❒	❒	Autumn
❒	❒	Cold	❒	❒	Heat
❒	❒	Dampness	❒	❒	Dryness
❒	❒	Open air (being outside)	❒	❒	Windows closed
❒	❒	Change of weather	❒	❒	Traveling
❒	❒	Ocean seashore	❒	❒	Mountains
❒	❒	Physical exertion	❒	❒	Upon rising
❒	❒	Morning	❒	❒	Evening
❒	❒	Cold application	❒	❒	Warm application
❒	❒	Bath	❒	❒	Before menstruation
❒	❒	During menstruation	❒	❒	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; P = a condition you have had in the past; N = never had

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
Itchy ears (inside ears/eat canal)	Y	P	N				

NOSE AND SINUSES

Frequent colds?	Y	P	N	Nose Bleeds?	Y	P	N
Stuffiness?	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	Blood clots?	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? _____ per day/week			
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 us to provide you with the best care possible. We look forward to working with you! -Dr. Lorina Shinsato & Alexander Kim