



**ADULT INTAKE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ (work): \_\_\_\_\_

Email address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: Female / Male

Education: \_\_\_\_\_

Married:\_\_\_ Separated:\_\_\_ Divorced:\_\_\_ Widowed:\_\_\_ Single:\_\_\_ Partnership:\_\_\_

Live with: Spouse:\_\_\_ Partner:\_\_\_ Parents:\_\_\_ Children:\_\_\_ Friends:\_\_\_ Alone:\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

How did you hear about this clinic/ doctor? \_\_\_\_\_

If internet: Google:\_\_\_ AANP Website:\_\_\_ OANP Website:\_\_\_ Other:\_\_\_\_\_

Has any other family member already been a patient at this clinic? \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Have you been to a naturopath before? Y / N Have you been to an acupuncturist before? Y / N

**CONTEXT OF CARE REVIEW**

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?



jorge kaufmann, ND, LAc, LLC  
5215 ne elam young pkwy, hillsboro, or 97124  
p: 503/693-9101 rosespringscenter.com

### CONTEXT OF CARE REVIEW

What do you know about our approach?

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

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0%    0    1    2    3    4    5    6    7    8    9    10    100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

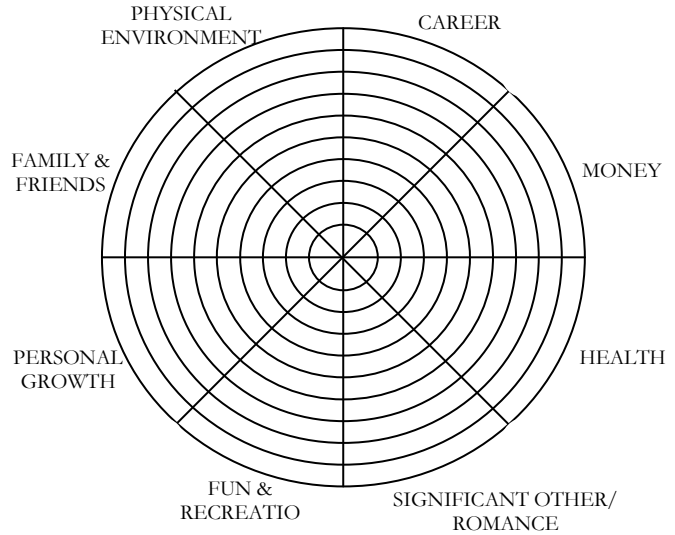


### WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? \_\_\_\_\_

If no, when and where did you last receive medical or health care? \_\_\_\_\_

What was the reason? \_\_\_\_\_

What are your most important health problems? List as many as you can in order of importance.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_

Do you have any known contagious diseases at this time? Yes / No

If yes, what? \_\_\_\_\_



**FAMILY HISTORY**

Do you or anyone in your family have a history of any of the following? (please circle and say who)

- |                |           |               |                     |
|----------------|-----------|---------------|---------------------|
| Cancer         | Diabetes  | Heart Disease | High Blood Pressure |
| Kidney disease | Epilepsy  | Arthritis     | Glaucoma            |
| Tuberculosis   | Stroke    | Anemia        | Mental Illness      |
| Asthma         | Hay fever | Hives         |                     |

Other relevant family history: \_\_\_\_\_

What is your family heritage? \_\_\_\_\_

**CHILDHOOD HISTORY**

City & State of Birth: \_\_\_\_\_ Time you were born: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Please circle whether you had any of the following as a child:

- |                 |            |               |             |
|-----------------|------------|---------------|-------------|
| Rheumatic fever | Diphtheria | Scarlet fever | Chicken pox |
| German Measles  | Measles    | Mumps         |             |

**HOSPITALIZATIONS/SURGERY/IMAGING**

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

\_\_\_\_\_ year \_\_\_\_\_ year \_\_\_\_\_  
 \_\_\_\_\_ year \_\_\_\_\_ year \_\_\_\_\_  
 \_\_\_\_\_ year \_\_\_\_\_ year \_\_\_\_\_

**ALLERGIES**

Are you hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental or chemicals? \_\_\_\_\_

**CURRENT MEDICATIONS**

Do you take or use any of the following (please circle):

- |                     |                     |                |                    |
|---------------------|---------------------|----------------|--------------------|
| Laxatives           | Pain relievers      | Antacids       | Cortisone          |
| Antibiotics         | Tranquilizers       | Sleeping Pills | Thyroid Medication |
| Birth Control Pills | Hormone Replacement |                |                    |

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

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



**GENERAL**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_

Maximum Weight: \_\_\_\_\_ When: \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

Main interests and hobbies: \_\_\_\_\_

Exercise: Y / N If so, what kind and how often: \_\_\_\_\_

Watch TV: Y / N If so, how many hours? \_\_\_\_\_ Read: Y / N If so, how many hours? \_\_\_\_\_

Do you have a religious or spiritual practice? Y / N If so, what kind? \_\_\_\_\_

**TYPICAL FOOD INTAKE**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

**FOR THE FOLLOWING, PLEASE CIRCLE:**

**Y** = a condition you have now

**N** = never had

**P** = a significant problem in the past

**GENERAL**

Do you sleep well? Y N P

Average 6-8 hours? Y N P

Awake rested? Y N P

Have a supportive relationship? Y N P

Have a history of abuse? Y N P

Experienced a major trauma? Y N P

Use recreational drugs? Y N P

Treated for drug dependence? Y N P

Use alcoholic beverages? Y N P

Use tobacco? Y N P

If in the past, how many years? \_\_\_\_\_

How many packs per day? \_\_\_\_\_

Do you enjoy your work? Y N P

Take vacations? Y N P

Spend time outside? Y N P

Eat three meals a day? Y N P

Do you go on diets often? Y N P

Do you eat out often? Y N P

Do you drink coffee? Y N P

Drink black/green tea? Y N P

Drink soda? Y N P

Do you eat refined sugar? Y N P

Do you add salt to your food? Y N P

**ENDOCRINE**

Hypothyroid? Y N P

Hypoglycemia? Y N P

Excessive thirst? Y N P

Fatigue? Y N P

Heat or cold intolerance? Y N P

Hyperthyroid? Y N P

Diabetes? Y N P

Excessive hunger? Y N P

Seasonal depression? Y N P

Difficulty exercising? Y N P

**IMMUNE**

Reactions to immunizations? Y N P

Chronically swollen glands? Y N P

Slow wound healing? Y N P

Chronic fatigue syndrome? Y N P

Chronic infections? Y N P

Night sweats? Y N P

**EARS**

Impaired hearing? Y N P

Ringing in ears? Y N P

Dizziness? Y N P

Ear aches? Y N P



**NEUROLOGIC**

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

**HEAD**

Headaches?	Y	N	P
Migraines?	Y	N	P
Head injury?	Y	N	P
Jaw or TMJ problems?	Y	N	P

**NOSE AND SINUS**

Frequent colds?	Y	N	P
Stuffiness?	Y	N	P
Sinus problems?	Y	N	P
Nose bleeds?	Y	N	P
Hayfever?	Y	N	P
Loss of smell?	Y	N	P

**RESPIRATORY**

Cough?	Y	N	P
Sputum?	Y	N	P
Asthma?	Y	N	P
Wheezing?	Y	N	P
Bronchitis?	Y	N	P
Coughing up blood?	Y	N	P
Pneumonia?	Y	N	P
Pleurisy?	Y	N	P
Difficulty breathing?	Y	N	P
Shortness of breath?	Y	N	P
“ “ when lying?	Y	N	P
Pain on breathing?	Y	N	P
Emphysema?	Y	N	P
Tuberculosis?	Y	N	P

**GASTROINTESTINAL**

Trouble swallowing?	Y	N	P
Change in thirst?	Y	N	P
Change in appetite?	Y	N	P
Nausea/vomiting?	Y	N	P
Ulcer?	Y	N	P
Jaundice?	Y	N	P
Gall bladder disease?	Y	N	P
Liver disease?	Y	N	P
Hemorrhoids?	Y	N	P
Pancreatitis?	Y	N	P
Heartburn?	Y	N	P

**EYES**

Impaired vision?	Y	N	P
Cataracts?	Y	N	P
Glaucoma?	Y	N	P
Spots in vision?	Y	N	P
Color blindness?	Y	N	P
Tearing or dryness?	Y	N	P
Eye pain or strain?	Y	N	P
Double vision?	Y	N	P

**NECK**

Lumps in neck?	Y	N	P
Goiter?	Y	N	P
Difficulty swallowing?	Y	N	P
Pain or stiffness in neck?	Y	N	P

**MOUTH AND THROAT**

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

**CARDIOVASCULAR**

Heart disease?	Y	N	P
Angina?	Y	N	P
High/Low blood pressure?	Y	N	P
Heart murmurs?	Y	N	P
Blood clots?	Y	N	P
Fainting?	Y	N	P
Phlebitis?	Y	N	P
Palpitations/fluttering heart?	Y	N	P
Chest pain?	Y	N	P
Rheumatic fever?	Y	N	P
Swelling in ankles?	Y	N	P

**SKIN**

Rashes?	Y	N	P
Acne/boils?	Y	N	P
Change in skin color?	Y	N	P
Lumps or bumps on skin?	Y	N	P
Eczema or hives?	Y	N	P
Itching?	Y	N	P
Perpetual hair loss?	Y	N	P

**MENTAL/EMOTIONAL**

Treated for emotional prob?	Y	N	P
Depression?	Y	N	P
Anxiety or nervousness?	Y	N	P



**GASTROINTESTINAL CONTINUED**

Abdominal pain or cramps? Y N P  
 Belching or passing gas? Y N P  
 Constipation? Y N P  
 Bowel movements: how often? \_\_\_\_\_  
 Is this a change? \_\_\_\_\_  
 Black stools? Y N P  
 Blood in stools? Y N P

**FEMALE REPRODUCTIVE**

Age of first menses: \_\_\_\_\_  
 Age of last menses (if menopausal): \_\_\_\_  
 Length of cycle: \_\_\_\_\_ days  
 Duration of menses: \_\_\_\_\_ days  
 Are your cycles regular? Y N P  
 Painful menses? Y N P  
 Heavy or excessive flow? Y N P  
 PMS? Y N P  
 Symptoms: \_\_\_\_\_  
 \_\_\_\_\_  
 Bleeding between cycles? Y N P  
 Clotting? Y N P  
 Endometriosis? Y N P  
 Ovarian cysts? Y N P  
 Vaginal odor? Y N P  
 Vaginal discharge? Y N P  
 Date of last pap smear: \_\_\_\_\_  
 Abnormal PAP? Y N P  
 Cervical dysplasia? Y N P  
 Are you sexually active? Y N P  
 Sexual orientation: \_\_\_\_\_  
 Birth control? Type: \_\_\_\_\_  
 Pain during intercourse? Y N P  
 Gonorrhea? Y N P  
 Herpes? Y N P  
 Chlamydia? Y N P  
 Genital warts? Y N P  
 Syphilis? Y N P  
 Difficulty conceiving? Y N P  
 Number of pregnancies: \_\_\_\_\_  
 Number of live births: \_\_\_\_\_  
 Number of miscarriages: \_\_\_\_\_  
 Number of abortions: \_\_\_\_\_  
 Do you do self breast exams? Y N P  
 Breast pain/tenderness? Y N P  
 Breast lumps? Y N P  
 Nipple discharge? Y N P  
 Menopausal symptoms? Y N P

**MENTAL/ EMOTIONAL CONTINUED**

Poor concentration? Y N P  
 Do you have mood swings? Y N P  
 Considered suicide? Y N P  
 Attempted suicide? Y N P  
 Tension? Y N P  
 Memory problems? Y N P

**URINARY**

Increased freq. of urination? Y N P  
 Inability to hold urine? Y N P  
 Pain on urination? Y N P  
 Frequency at night? Y N P  
 Frequent UTIs? Y N P  
 Kidney stones? Y N P

**MUSCULOSKELETAL**

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

**BLOOD**

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

**MALE REPRODUCTIVE**

Are you sexually active? Y N P  
 Sexual orientation: \_\_\_\_\_  
 Birth control? Type: \_\_\_\_\_  
 Discharge or sores? Y N P  
 Chlamydia? Y N P  
 Gonorrhea? Y N P  
 Genital warts? Y N P  
 Herpes? Y N P  
 Syphilis? Y N P  
 Hernias? Y N P  
 Testicular masses? Y N P  
 Testicular pain? Y N P  
 Prostate disease? Y N P  
 Impotence? Y N P  
 Premature ejaculation? Y N P

**Thank you for your time and effort. I look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the back of this page.**