Issaquah Holistic Health, PLLC *Health Care for a Higher Quality of Life*
Alexandria Easter, ND • 450 NW Gilman Blvd Suite 201, Issaquah WA 98027
P: (425) 395-7542 F: (425) 657-0934

Confidential Adult Patient Intake Form:

Date_____

Name _____ Date of Birth _____ Sex M/F _____

Address _____

City/State/Zip _____

Phone (home) _____ (cell) _____ (email) _____

Emergency Contact _____ Ph _____ Relation _____

Insurance _____ Name of Insured_____

Date of Birth of Insured _____ Copay Amount_____

How did you hear about us? _____

Relationship Status: ☐ Single ☐ Married ☐ Significant Other

Occupation _____ Do you enjoy your work? _____

Current health concerns:

_____

_____

Allergies to medications, foods, insects, pollens _____

_____

Current Medications and Dosage

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

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Current Supplements

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Family History:

	Mother	Father	Sibling	Grandparent	Child	Aunt/Uncle
Hypertension	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Crohn's Disease/ Ulcerative Colitis	☐	☐	☐	☐	☐	☐

Kids:

Name, Age, and Health Issues _____

_____

Personal History:

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Do you currently have any diagnosed medical conditions? _____

_____

Major Illnesses/Accidents (please include dates)? _____

_____

Review of Systems: (Current or Past)

☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Abdominal Pain	☐ Hemorrhoids	☐ Asthma	☐ Allergies
☐ Eczema	☐ Psoriasis	☐ Rash	☐ Hives
☐ Fatigue	☐ Headache	☐ Joint Pain	☐ Dizziness
☐ Numbness	☐ Tingling	☐ Muscle Pain	☐ Weakness
☐ Hair loss	☐ Brittle nails	☐ Anemia	☐ Thyroid Issue
☐ Weight Loss	☐ Diabetes	☐ Heart Attack	☐ Stroke
☐ Hypertension	☐ High Cholesterol	☐ Irregular Menses	☐ Cramps
☐ PMS	☐ Missed Cycles	☐ Painful Breasts	☐ Painful Urination
☐ Hotflashes	☐ Pelvic Pain	☐ Heavy Flow	☐ Varicose Veins
☐ Enlarged Prostate	☐ Difficult Urine Flow	☐ Back Pain	☐ Bleeding Gums
☐ Kidney Stones	☐ Hepatitis	☐ STD	☐ Chest Pain
☐ Leg swelling	☐ Shortness of Breath	☐ Ringing Ears	☐ Hearing Loss
☐ Change Taste/Smell	☐ Change in Vision	☐ Frequent Sore Throat	☐ Frequent Sinusitis
☐ Weight Gain	☐ Irregular Heart Beat	☐ Difficulty Swallowing	☐ Kidney Disease
☐ Depression	☐ Anxiety/Panic Attacks	☐ Attention Issues	☐ Memory Loss

Current Exercise: _____

Amount and Frequency _____

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Diet/Digestion/Genitourinary:

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Do you have experience constipation, diarrhea, bloating/gas, or reflux/indigestion? _____

Bowel Movements, Frequency _____

Is it difficult to have a bowel movement? _____ Does it contain blood or mucus? _____

Do you urinate frequently or wake in the night to urinate? _____

Do you experience incontinence or burning/pain with urination? _____

(Females) Date of last menstrual period _____ Number of Pregnancies _____

Miscarriges _____ Complications with Pregnancy _____

(Men) Difficult urinary flow? _____ Erectile Dysfunction? _____

Date of last physical exam _____ Date of last blood work/labs _____

How is your energy level? _____

How many hours a night do you sleep? _____ Do you have trouble falling asleep or staying asleep?

_____

Habits:

Smoking ☐ Currently ☐ Previously Amount/Frequency _____

Alcohol ☐ Currently ☐ Previously Amount/Frequency _____

Recreational Drugs ☐ Currently ☐ Previously Amount/Frequency _____