Steve Clark ND PLLC

Dr. Steve Clark ND
Dr. Erik O Nelson ND

Last name____________________________ First name_____________________________ MI_______

Mailing address______________________________ Town, state, zip ____________________________

Phone # (H)______________________ (W)________________________ (Cell)__________________

Email_______________________________ Date of Birth___________________ Age_____________

How did you hear about us?__________________________

Height____'_____" Blood Pressure_______/________ When?_________________________

Weight (current)______lbs One year ago______lbs Max weight_______lbs When?_____________

Do you know what Naturopathic medicine is? Yes____ No____

How familiar are you with "health foods"? Use the scale below.

Not at all 1 2 3 4 5 6 7 8 9 10 Very familiar

What current health goals would you like to address with Dr. Clark?

1.____
2.____
3.____
4.____
5.____

To the best of your memory, please give a brief description of what you ate for breakfast, lunch, and dinner in the last two to three days. Include snacks, beverages and water intake.

//////////////////	TODAY	YESTERDAY	DAY BEFORE
BREAKFAST			
LUNCH			
DINNER			
SNACK			

Does this represent a "normal" diet for you? Yes______ No_______

If not, please explain:____
____
____

Alcohol use: Drinks/day?___________________ For how long______________________

Cigarette use: _____No _____Yes , pack/day_____________ For how long ____________

Recreational drugs: _____ No Yes, specify:

Symptoms Questionnaire:
Please check the box for appropriate current or past symptoms.

	Present	**Past**	**Severity** **Mild**	**Severe**
CIRCULATION				
Deep leg pain	☐	☐	☐	☐
Cold hands/feet	☐	☐	☐	☐
Swelling in ankles	☐	☐	☐	☐
Easy bleeding/bruising	☐	☐	☐	☐
DIGESTIVE				
Nausea/vomiting	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Bloated feeling	☐	☐	☐	☐
Belching or gas	☐	☐	☐	☐
Heartburn	☐	☐	☐	☐
Change in thirst	☐	☐	☐	☐
Change in appetite	☐	☐	☐	☐
Blood in stool	☐	☐	☐	☐

Bowel movements: How often?____________ Is this a change? Yes_____ No______

EARS				
Ear aches/infections	☐	☐	☐	☐
Itchy	☐	☐	☐	☐
Ringing/hearing loss	☐	☐	☐	☐
EMOTIONAL				
Mood swings	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Anger/irritability	☐	☐	☐	☐
Depression	☐	☐	☐	☐
ENDOCRINE				
Heat or cold intolerant	☐	☐	☐	☐
Excessive thirst	☐	☐	☐	☐
Excessive hunger	☐	☐	☐	☐
ENERGY				
Fatigue/sluggishness	☐	☐	☐	☐
Apathy/lethargy	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐
Restlessness	☐	☐	☐	☐
EYES				
Watery/itchy	☐	☐	☐	☐
Swollen/red/sticky	☐	☐	☐	☐
Pain	☐	☐	☐	☐

	Present	**Past**	**Severity** **Mild**	**Severe**
Dry eyes	☐	☐	☐	☐
Blurred/tunnel/double vision	☐	☐	☐	☐

HEAD

Headache/migraine….. ☐ ☐ ☐ ☐
Faintness……………. ☐ ☐ ☐ ☐
Dizziness…..………… ☐ ☐ ☐ ☐
Insomnia…..………… ☐ ☐ ☐ ☐
Jaw pain……………. ☐ ☐ ☐ ☐

HEART

Irregular or skipped beat…. ☐ ☐ ☐ ☐
Rapid or pounding….. ☐ ☐ ☐ ☐
Chest pain…………… ☐ ☐ ☐ ☐

JOINTS OR MUSCLES

Pain in joints……….. ☐ ☐ ☐ ☐
Stiffness or limitations. ☐ ☐ ☐ ☐
Pain or aches in muscle ☐ ☐ ☐ ☐
Muscle weakness……. ☐ ☐ ☐ ☐

LUNGS

Chest congestion……. ☐ ☐ ☐ ☐
Deep chest coughing… ☐ ☐ ☐ ☐
Shortness of breath….. ☐ ☐ ☐ ☐
Difficulty breathing…. ☐ ☐ ☐ ☐
Pain on breathing……. ☐ ☐ ☐ ☐
Spitting up blood……. ☐ ☐ ☐ ☐
Wheezing…………… ☐ ☐ ☐ ☐

MIND

Poor memory……….. ☐ ☐ ☐ ☐
Confusion…………… ☐ ☐ ☐ ☐
Poor concentration….. ☐ ☐ ☐ ☐

MOUTH AND THROAT

Chronic coughing…… ☐ ☐ ☐ ☐
Gagging or throat clearing …… ☐ ☐ ☐ ☐
Sore throat/horse……. ☐ ☐ ☐ ☐
Swollen or discolored tongue. ☐ ☐ ☐ ☐
Canker sores……….. ☐ ☐ ☐ ☐
Difficulty swallowing. ☐ ☐ ☐ ☐

Severity
Present **Past** **Mild** **Severe**

NECK

Lumps……..……….. ☐ ☐ ☐ ☐
Swollen glands……… ☐ ☐ ☐ ☐
Pain or stiffness……… ☐ ☐ ☐ ☐
Muscle tension………. ☐ ☐ ☐ ☐

NEUROLOGIC

Seizures……………… ☐ ☐ ☐ ☐
Paralysis…..………… ☐ ☐ ☐ ☐

Numbing or tingling… ☐ ☐ ☐ ☐
Vision changes……… ☐ ☐ ☐ ☐

NOSE
Stuffy nose..……….. ☐ ☐ ☐ ☐
Sinus problems……… ☐ ☐ ☐ ☐
Hay fever…..………. ☐ ☐ ☐ ☐
Sneezing attacks…….. ☐ ☐ ☐ ☐
Excessive mucus……. ☐ ☐ ☐ ☐
Nose bleeds..……….. ☐ ☐ ☐ ☐

SKIN
Acne/boils…………… ☐ ☐ ☐ ☐
Hives/rash/dry skin…. ☐ ☐ ☐ ☐
Hair loss…..………… ☐ ☐ ☐ ☐
Flushing or hot flashes. ☐ ☐ ☐ ☐
Excessive sweating…. ☐ ☐ ☐ ☐
Night sweats………… ☐ ☐ ☐ ☐
Itching……..………… ☐ ☐ ☐ ☐
Color change………… ☐ ☐ ☐ ☐
Lumps……..………… ☐ ☐ ☐ ☐
Rashes……..………… ☐ ☐ ☐ ☐

URINARY
Pain on urination……. ☐ ☐ ☐ ☐
Increased frequency… ☐ ☐ ☐ ☐
of urination
Frequency at night….. ☐ ☐ ☐ ☐
Inability to hold urine.. ☐ ☐ ☐ ☐

WEIGHT
Binge eating/drinking.. ☐ ☐ ☐ ☐
Craving certain foods.. ☐ ☐ ☐ ☐
Excessive weight……. ☐ ☐ ☐ ☐
Compulsive eating….. ☐ ☐ ☐ ☐
Water retention……… ☐ ☐ ☐ ☐
Underweight………… ☐ ☐ ☐ ☐

FEMALE REPRODUCTIVE (if applicable)
Age menses began ________years old
Average length of cycle ________days
Average length of bleeding ________days
Are you sexually active? ______No ______Yes
Do you use birth control? ______No ______Yes
Which method of birth control?____
Number of pregnancies ________
Number of live births ________
Number of miscarriages ________
Number of abortions ________

	Present	**Past**
Bleeding between…… periods	☐.	☐

Pain during intercourse ☐ ☐
Painful menses.......... ☐ ☐
Irregular cycles......... ☐ ☐
Excessive flow.......... ☐ ☐
Menopausal symptoms ☐ ☐
Sexual difficulties...... ☐ ☐
Sexually transmitted... ☐ ☐
disease

BREAST Do you do self exams? ____No _____Yes
Lumps........ ☐ ☐
Pain or tenderness...... ☐ ☐
Discharge............... ☐ ☐

Have you used any hormone modulating treatments: Ie birth control, bioidentical hormones, estrogen replacement. Hormone blockers including hormone modulating chemotherapy:
Specify:

MALE REPRODUCTIVE (if applicable)
Hernias.................. ☐ ☐
Testicular masses....... ☐ ☐
Testicular pain.......... ☐ ☐
Prostate disease......... ☐ ☐
Discharge or sores...... ☐ ☐
Sexually transmitted... ☐ ☐
disease
Sexual difficulties...... ☐ ☐
Are you sexually active? ____No _____Yes

Have you used any hormone modulating treatments: Ie bioidentical hormones, testosterone replacement. Hormone blockers including hormone modulating chemotherapy:
Specify:

FAMILY history of significant illness:

____
____
____
____
____
____

Have you had any ALLERGY OR INFLAMMATORY REACTIVE SYMPTOMS to internal or external triggers including,
Food allergies/reactions, chemical sensitivity, environmental exposure reactions, topical dermatitis, etc.

____
____
____
____
____
____

OTHER HEALTH CONCERNS, CHRONIC CONDITIONS, ISSUES OF NOTE:

____
____
____
____
____
____

Medications & Supplements (attach separate sheet if necessary):

____
____
____
____
____
____
____
____
____
____
____

_________________________________ _____________________________
Signature Date