Office of Erik W. Gilbertson, D.C., N.D.
Naturopathic Medical Doctor and Chiropractor
The Natural Path to Health
Phone: (253) 579-3958

PATIENT HEALTH HISTORY

Patient Name: _____
First Middle Last

Natural medicine healthcare is possible only when the physician or practitioner completely understands the patient's physical, mental, and emotional conditions. The information you provide helps your practitioner understand your needs and how to help you reach your health goals. Feel free to mark anything you may have a question about. **Please write legibly and answer all questions thoroughly.**

Address: _____

City: _____ State: _____ Zip code: _____

Telephone numbers: Home: _____ Cell: _____

Preferred # for appointment reminders and other messages – no health information will be disclosed: _____

Email: _____ Birth date: _____

Age: _____ Gender (circle one): M F Number of children you have: _____

Occupation: _____ Hours per week: _____

Employer: _____ Employer address: _____

Marital status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced

With whom do you live? ☐ Spouse ☐ Parents ☐ Friends ☐ Children ☐ Alone

Spouse/parent name: _____ Spouse/parent birth date:_____

Spouse/parent phone: _____

Spouse/parent address (if not same as above)_____

Insurance Company: _____ Group #: _____

Insurance Company Address (on back of card): _____

Policy #: _____

How did you hear about our clinic? _____

May we thank the person that referred you? _____

Emergency contact: _____

Relationship: _____ Telephone number: _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Erik Gilbertson, D.C., N.D. to release information necessary to secure payment.

Signature: _____ Date: _____

Patient History

What is the main reason for your visit to our clinic today? _____
_____

When did you last visit a doctor's office, medical clinic, or hospital? Please explain. _____

_____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain: _____

_____

What hospitalizations or surgeries have you had? _____
_____

_____

What diagnostic imaging studies have you had? ☐ Bone density scan ☐ Mammogram
☐ Electrocardiogram ☐ Electroencephalogram ☐ X-rays ☐ CT scan ☐ MRI

Medications and/or Supplements

Do you take or use any of the following?

- ☐ Pain relievers (aspirin, ibuprofen)
- ☐ Antacids
- ☐ Diet pills, appetite suppressants
- ☐ Laxatives
- ☐ Cortisone (cream or pills)
- ☐ Tranquilizers
- ☐ Thyroid medication
- ☐ Antibiotics
- ☐ Sleeping pills

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

_____

_____

_____

General

Height: _____ Weight: _____lbs. Weight one year ago: _____lbs.
Maximum weight: _____lbs. When? _____
When during the day is your energy best? _____ Worst? _____

Family History

Do you have a family history of any of the following (please circle)?

Anemia	Diabetes	Hayfever/hives	Liver disease
Arthritis	Epilepsy	Heart disease	Mental illness
Asthma	Gall bladder disease	Heart murmur	Stroke
Cancer	Glaucoma	High blood pressure	Tuberculosis
Cataracts	Goiter	Kidney disease	

Is your father still living? Yes; his age ____ No; age at time of death _____ Cause of death _____

Is your mother still living? Yes; her age ____ No: age at time of death _____ Cause of death _____

Childhood Illnesses

Please circle whether you have/had any of the following conditions as a child/adolescent:

Diptheria	Mumps
German measles	Rheumatic fever
Measles	Scarlet fever
Other _____	

Past Immunizations

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diptheria	Polio
Measles/Mumps/Rubella (MMR)	Tetanus
Pertussis	Other _____

Review of Systems

Please circle. Y= Yes, present condition. N=No, never had the condition. P=Problem of the past.

Head

Headaches	Y P N	Migraine headaches	Y P N
Head injury	Y P N	Jaw/TMJ problems	Y P N

Ears

Ringing	Y P N	Dizziness	Y P N
Earaches	Y P N	Impaired hearing	Y P N

Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

Skin

Rashes	Y P N	Psoriasis	Y P N	Eczema, hives	Y P N
Lumps	Y P N	Acne, boils	Y P N	Color changes	Y P N
Itching	Y P N	Loss of hair	Y P N	Night sweats	Y P N

Review of Systems (continued)

Please circle. Y= Yes, present condition. N=No, never had the condition. P=Problem of the past.

Musculoskeletal

Joint pain	Y P N	Muscle spasms	Y P N	Weakness	Y P N
Arthritis	Y P N	Broken bones	Y P N	Sciatica	Y P N

Eyes

Blurred vision	Y P N	Cataracts	Y P N	Glasses/contacts	Y P N
Eye pain/strain	Y P N	Glaucoma	Y P N	Tearing/dryness	Y P N
Spots in eyes	Y P N	Color blind	Y P N	Double vision	Y P N

Nose/Sinuses

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

Mouth/Throat

Hoarseness	Y P N	Gum problems	Y P N	Freq. sore throat	Y P N
Jaw clicks	Y P N	Dental cavities	Y P N	Sore lips/tongue	Y P N

Respiratory

Asthma	Y P N	Wheezing	Y P N	Spitting up blood	Y P N
Cough	Y P N	Bronchitis	Y P N	Difficulty breathing	Y P N
Sputum	Y P N	Pneumonia	Y P N	Pain with breathing	Y P N
Pleurisy	Y P N	Emphysema	Y P N	Shortness of breath	Y P N
		Tuberculosis	Y P N	at night	Y P N
				lying down	Y P N

Cardiovascular

Angina	Y P N	Chest pain	Y P N	Blood clots	Y P N
Murmur	Y P N	Heart disease	Y P N	Rheumatic fever	Y P N
Fainting	Y P N	Ankle swelling	Y P N	Low/high blood pressure	Y P N

Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Changes in thirst	Y P N
Ulcers	Y P N	Black stool	Y P N	Coughing up blood	Y P N
Jaundice	Y P N	Hemorrhoids	Y P N	Gall bladder disease	Y P N
Heartburn	Y P N	Abdominal pain	Y P N	Blood in stool	Y P N
Liver disease	Y P N	How many bowel movements per day? _____			

Urinary

Incontinence	Y P N	Frequent infections	Y P N	Painful urination	Y P N
Kidney stones	Y P N	Frequency at night	Y P N		

Blood/Peripheral Vascular

Anemia	Y P N	Cold hands/feet	Y P N	Thrombophlebitis	Y P N
Leg pain	Y P N	Easy bruising	Y P N	Varicose veins	Y P N

Neurological

Fainting	Y P N	Paralysis	Y P N	Numbness/tingling	Y P N
Seizures	Y P N	Loss of memory	Y P N	Muscle weakness	Y P N

Emotional

Mood swings	Y P N	Nervousness	Y P N	Tension/stressed	Y P N
Anxiety	Y P N	Depression	Y P N		

Endocrine

Hypothyroid	Y P N	Excessive thirst	Y P N	Cold intolerance	Y P N
Hyperthyroid	Y P N	Excessive hunger	Y P N	Heat intolerance	Y P N

Male Reproductive

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Prostate issues	Y P N	Sexual difficulty	Y P N	Testicular pain	Y P N
Venereal disease	Y P N	Premature ejaculation	Y P N		

Female Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____

Length of cycle _____ Duration of menses _____

Date of last annual exam _____

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N
Breasts tender	Y P N	Venereal disease	Y P N	Bleeding between cycles	Y P N
Sexually active	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Sexual difficulty	Y P N	Abnormal pap	Y P N	PMS	Y P N
Breast lump(s)	Y P N	Nipple discharge	Y P N	Do self breast exams	Y P N

Birth control Y P N If yes, what type?_____

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____ Number of abortions _____

Is there anything else you would like us know in order to serve you better?

_____

_____

_____

_____

_____

_____

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service, and no financial arrangement has been made, you will be responsible for any expenses incurred in collecting your account.

I hereby authorize payment of benefits directly to the provider of benefits due me for services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed to the best of my knowledge, and understand it is my responsibility to inform this office of any changes in my medical status.

Signature of Responsible Person:_____Date: _____/_____/_____