Radiant Heart Center for Wholeness
Ali Givens, ND Michael Givens, Lac
12160 SE Mt. Scott Blvd.
Happy Valley, OR. 97086
503.609-0890

PATIENT INTAKE FORM

Name: _____
Address: _____
City: _____ State: _____ Postal Code: _____
Phone (Home): _____ (Work): _____ (Cell): _____
E-mail: _____
Male ❒ Female ❒ Date of Birth: _____
Occupation: _____ Employed By: _____
Marital Status: _____ Number of children: _____
What contact number do you prefer we use? _____ May we leave a message? _____

Emergency Contact: _____ Phone: _____ Relation: _____
Name of Medical Doctor: _____ Phone: _____

How did you hear about me? Friends ❒ Family ❒ Presentation ❒ Website ❒
Newspaper ❒ Other: _____

Health Concerns

What are your main health concerns in order of importance to you?

_____
_____
_____

Vitamins and Supplements

Please list all vitamin/mineral/herbal supplements you are currently taking:

Supplement (Including Brand)	Dosage	When did you begin this supplement?

Medications

Please list all prescription and non-prescription medications you are currently taking:

Medication	Dosage	When did you begin this medication?

Please list all prescription medications you have taken in the past for longer than six months. Indicate how long you took each medication.

_____

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Family History

Next to each individual listed below, please put an "L" for living or "D" for deceased, as well as present age or age at the time of death. Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Mother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Sister(s)			
Brother(s)			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

Medical History

Please list any injuries and/or major surgery you have had and when they occurred:

Please list any major illnesses or diseases that you have or have had:

Vaccinations (please check)

- ❑ DPT (Diphtheria, Pertussis, Tetanus)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ Chicken Pox
- ❑ Polio
- ❑ Flu Shot
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Other _____

Did you experience any adverse effects from them? If yes, please explain.

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Please check "✓" any of the following that apply to you or write "P" beside the box if you have experienced any in the past.

General
- ❑ Fatigue
- ❑ Change in appetite
- ❑ Change in thirst
- ❑ Cravings
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Chills or fever
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Allergies
- ❑ Cancer
- ❑ Diabetes

Skin and Hair
- ❑ Dryness
- ❑ Rash
- ❑ Itching
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Recent moles
- ❑ Hives or allergic reactions
- ❑ Loss of hair
- ❑ Thinning hair
- ❑ Dandruff
- ❑ Other skin problem(s)

Respiratory
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Asthma
- ❑ Wheezing
- ❑ Coughing blood
- ❑ Phlegm in throat

Eyes Ears Nose & Throat
- ❑ Eye pain
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Impaired vision
- ❑ Cataracts
- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Vertigo or dizziness
- ❑ Sinus infections
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Loss of smell/taste
- ❑ Sores in mouth
- ❑ Mercury fillings
- ❑ Jaw pain or clicks
- ❑ Recurrent sore throat
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Facial pain/tics
- ❑ Headaches

Neurological
- ❑ Anxiety
- ❑ Depression
- ❑ Irritability
- ❑ Emotional problems
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Dizziness
- ❑ Seizures/Epilepsy
- ❑ Concussion
- ❑ Lack of coordination
- ❑ Extremity numbness
- ❑ Extremity tingling
- ❑ Paralysis

Cardiovascular
- ❑ Chest pain
- ❑ Palpitations
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ Irregular heartbeat
- ❑ Pacemaker
- ❑ Artificial heart valve
- ❑ Stroke
- ❑ Fainting
- ❑ Varicose veins
- ❑ Deep leg pain
- ❑ Cold hands or feet
- ❑ Swelling of limbs
- ❑ Anemia
- ❑ Easy Bruising

Muscle Bone & Joints
- ❑ Neck pain
- ❑ Back pain
- ❑ Arthritis
- ❑ Bursitis
- ❑ Joint pain or stiffness
- ❑ Artificial joint
- ❑ Muscle pain
- ❑ Muscle weakness

Urinary
- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Incontinence
- ❑ Pain on urination
- ❑ Waking at night to urinate
- ❑ Urinary tract infection
- ❑ Blood in urine
- ❑ Kidney stones

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Infections

- ❑ Strep throat
- ❑ Mononucleosis
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ HIV/AIDS

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Reflux or heartburn
- ❑ Constant hunger
- ❑ Ulcer
- ❑ Indigestion
- ❑ Abdominal pain or cramping
- ❑ Bloating
- ❑ Gall stones
- ❑ Liver disease
- ❑ Jaundice
- ❑ Intestinal parasites
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Chronic laxative use
- ❑ Rectal burning/pain
- ❑ Hemorrhoids
- ❑ Blood in stool

Male Reproductive

- ❑ Prostate problem
- ❑ Impotence
- ❑ Sexually transmitted disease
- ❑ Sores on genitals
- ❑ Discharge
- ❑ Testicular Mass
- ❑ Testicular pain
- ❑ Infertility/low sperm count
- ❑ Hernia

Female Reproductive

- ❑ Irregular periods
  - ❑ Heavy
  - ❑ Light
  - ❑ Clots
- ❑ Painful periods
- ❑ PMS
- ❑ Sore breasts with menses
- ❑ Infertility
- ❑ Sexually transmitted disease
- ❑ Vaginal sores
- ❑ Vaginal discharge

Date of last Pap _____
Age of first menses ___

Menopausal Y N
Age of last menses ___

Pregnant Y N

Do you practice birth control? Y N
Type _____

Number of:
- Pregnancies _____
- Abortions _____
- Miscarriages _____
- Births _____

Breasts

- ❑ Lumps
- ❑ Tenderness
- ❑ Nipple discharge

Do you do breast self-exams? Y N

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Personal Habits and Lifestyle

How many cups/bottles/glasses do you drink, on average, per day?

Coffee	Milk 2%	Fruit Juice
Tea	Skim Milk	Soft Drinks (diet)
Water	Beer	Soft Drinks (regular)
Herbal Tea	Wine	Vegetable Juice
	Liquor	Other

Please check "✓" the source of your drinking water.

Tap (city)		Well		Bottled (spring)		Filtered		Distilled	

Do you smoke? Y N If yes, how many per day? _____
Do you use recreational drugs? Y N

How frequently do you move your bowels? _____ Per day or per week? _____
How many hours of sleep do you get on average? _____
Do you feel refreshed in the morning? Y N
Do you have trouble falling asleep? Y N
Do you have trouble staying asleep? Y N

How many hours do you work each day? _____
Do you often feel overworked? Y N
Do you exercise? Y N If yes, how often?_____
What do you do for exercise? (indicate activity, frequency, intensity and duration)

_____

_____

Diet

Diet: ❒ Non Vegetarian ❒ Vegetarian ❒ Vegan For how long? _____

Known Food Allergies/Intolerance:

_____

Known Environmental Allergies/Sensitivities:

_____

_____

Have you tried any particular diets (i.e. Paleo, Blood Type, Alkaline etc.), if yes, which ones and what were the results?

_____

_____

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Food and Water Intake

For the following table, please include the times you eat your meals, and a sample meal you may eat on any given day. If you are experiencing symptoms after any particular meal, please indicate those as well. If there is anything else you associate with your meals, please write them in the notes section.

	Time(s)	Sample	Symptoms	Notes
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Beverages				
Desserts				

- Are your meals regular? (Please Circle) Yes No
- How much time is there between finishing your last meal and bedtime? _____

Thank you for taking the time to fill out this form!! ~Dr. Ali and Michael