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Phone: 503 943- 9842

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone # Home _____ Work _____ Cell _____

Age _____ Date of Birth _____ Gender _____

Married ___ Separated ___ Partner ___ Divorced ___ Widowed ___ Single ___ Other _____

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone _____

Education _____ Occupation _____ Hrs/wk _____ Retired _____

Employer _____ E Mail Address _____

Work Address _____

Health Insurance name _____

Health Insurance address _____

Insurance phone # _____ Policy ID# _____ Group# _____

Policy holder's name _____ Employer of Policy Holder _____

How did you hear about our clinic _____

Next of Kin or other to reach in an emergency _____ Relationship _____

Phone _____ Address _____

Are you currently receiving healthcare? _____

If yes, where and from whom? If no, when did you last receive health care and for what reason? _____

Lifestyle Survey:

Do you follow any special diet; if Yes, what kind? _____

Tobacco- smoke ___chew_____ How much per day ? _____ Approx. date started _____ Date quit _____

Alcohol- how many drinks/day? (1 drink=12oz beer/6oz wine/1 oz liquor): _____

Coffee (decaf or regular) tea (herbal/caffeinated) soft drinks (caffeinated/ diet) chocolate or other caffeine containing products _____

Regular Exercise? How many hours per week? _____ What type? _____

Spiritual Practices? _____

Recreational Drugs? _____

Are you allergic or hypersensitive to any? Drugs, foods or environmental factors (perfume, pollen, etc.)? _____

Current Medications (include non-prescription & prescription medications):

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any Herbs/Vitamins/Supplements you are Currently Taking:

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

History of Surgery &/or Serious Injury:

Type of Occurrence	Date	Type of Occurrence	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal Medical History:

Anemia	Yes	No	Gastrointestinal Disease	Yes	No
Diabetes	Yes	No	(Stomach) Ulcers	Yes	No
Thyroid Disorder	Yes	No	Gallbladder Disease	Yes	No
Arthritis	Yes	No	Liver Disease	Yes	No
Kidney Disease	Yes	No	Hepatitis	Yes	No
Bladder Infections	Yes	No	Respiratory Disorder	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No
High Cholesterol	Yes	No	Pneumonia	Yes	No
Stroke/TIA	Yes	No	Sexual Transmitted		
Headache	Yes	No	Infection- type _____		
_____migraine_____tension_____cluster			Eating Disorder	Yes	No
Blood Transfusion	Yes	No	Chronic Fatigue Syndrome	Yes	No
Seasonal Allergies	Yes	No	Cancer – type _____	Yes	No
Skin Disorders	Yes	No	Depression/Anxiety	Yes	No
Type _____			Eye, Ear, Nose, Throat	Yes	No
Sexual Dysfunction	Yes	No	Dental Problems	Yes	No
Sleep Habits _____					
Bowel Habits _____					

Menstrual History (women)

Last menstruation _____ Cycle duration (days between period) _____ PMS _____
 Period length _____ Flow quality (clots, bright, heavy, light) _____
 Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____
 Current Birth Control _____

Family History

<i>Disease</i>	<i>Relationship to You</i>	<i>Disease</i>	<i>Relationship to You</i>
Diabetes	_____	Alcoholism	_____
Heart Disease	_____	Thyroid Disorder	_____
Hypertension	_____	High Cholesterol	_____
Cancer (type)	_____	Bleeding Disorder	_____
	_____	Arthritis (type)	_____
Stroke	_____	Seizures	_____
Birth Defects	_____	Osteoporosis	_____
Mental Illness	_____	Other	_____

Specific Health Problem(s) You would like to Address Today:
