Sojourns COMMUNITY HEALTH CLINIC

NEW CLIENT HEALTH INFORMATION (REVISED 04/2014)

Sojourns' practitioners work in collaboration with each other. We discuss care options at a daily meeting. We feel that we can offer the most to our patients when we continually learn from each other's experience and expertise. Information about patients is shared amongst Sojourns' practitioners for treatment and follow-up purposes ONLY.

Do you agree the information in your file may be shared? (Circle Yes if it is okay to share, circle No if you prefer your information not be shared.) Yes No

_____
Signature

Your name: _____ Today's date: _____

Your birth date: _____ Primary Care Provider: _____

Please list your major health concern(s):

Concern(s):	When did it start?

If there are conditions or diagnosis not listed above, please list:

Condition/Diagnosis	When?

Do you have allergies? Please specify:

__Food_____
__Drugs/Medications_____
__Environmental/Chemical_____
__Seasonal_____
__Other _____

How do any of these issues affect your daily activities? _____

_____

_____

_____

What are your goals for your treatment at Sojourns? _____

_____

_____

_____

What might stand in the way of you achieving your goals? _____

_____

_____

_____

What gives you the most joy in life? _____

_____

_____

_____

What will you do when you are well that you are not doing now? _____

_____

_____

_____

Please list name and location (city & State) of any other health professional currently involved in your care:

Name of Provider:	Specialty:	Treating you for:	City & State

Hospitalizations and Surgeries (Please include dates): _____

_____

_____

_____

Accidents (If today's visit is because of an accident, please fill out our accident report form available at the desk):
_____

_____

_____

Significant Traumas: _____

_____

_____

Birth History (prolonged labor, forceps delivery, etc): _____

_____

Dental History:
Do you have any metal dental fillings or crowns? __No __Yes __Not Sure ___Past? ___Present?

Have you had any major dental work (root canal, bridge, implant)? Please describe:_____

_____

_____

Please tell us about your family:

Family Member	Current Age(s)	If Deceased, Age & Cause
Mother		
Father		
Siblings		
Children		
Spouse or Partner		

Please identify your Family Medical History (circle, and write which family member):
Stroke_____ Heart Disease_____ High Blood Pressure_____

Depression/Anxiety_____ Alcohol/Drug Abuse_____

Diabetes_____ Autoimmune Disease_____ Seizures_____

Thyroid Disease_____ Mental Illness_____ Asthma_____

Cancer (list types): _____

_____

Other notes: _____

_____

Do you know your **Blood Type**? __A + / - __AB + / - __B + / - __O + / - __Don't know

Sojourns Community Health Clinic Name: _____

Please identify some of your lifestyle habits:

Please tell us about your diet: __Not Restricted __Vegetarian __Vegan __Other Restrictions

If restricted, please explain: _____

_____

_____

Typical Daily Diet:

Morning:

Afternoon:

Evening:

How much water do you drink each day? _____ glasses (8 oz) per day

What else do you regularly drink (and how much)? _____

Please fill in current and past use of the following substances:

Substance	Used in past?	What? How much per day?	Use Now?	What? How much per day?
Tobacco	Yes No		Yes No	
Recreational Drugs	Yes No		Yes No	
Alcohol	Yes No		Yes No	
Coffee/Caffeinated Tea	Yes No		Yes No	
Energy Drinks (caffeine)	Yes No			
Soft drinks	Yes No			
Artificial Sweeteners	Yes No		Yes No	

Are you aware of any toxic/chemical exposure in your home or workplace? _____

Are you sensitive to fragrances or environmental chemicals? _____

Are you sensitive to molds? Is there mold exposure at home?_____

If Yes to any of the above, please describe:_____

_____

_____

Lyme Disease Risk: (Please check all that apply)

Tick infested area ___ Frequent outdoor activities ___ Hiking ___ Fishing ___ Camping ___ Gardening ___ Hunting ___ Farming ___ Ticks on pets ___

Do you remember a tick bite? No __ Yes __ When? _____

Do you remember a "bull's eye" rash? No __ Yes __ When? _____

Other rash? No __ Yes __ When? _____

Have you received the Lymerix vaccine? No __ Yes __ When? _____

Have you ever been diagnosed and/or treated for Lyme disease or tick borne illness? No___ Yes__ When?____

Sojourns Community Health Clinic Name: _____

Current Weight: _____ Ideal Weight: _____ Highest Adult Weight: _____ Lowest Adult Weight: _____
Height:_____

Do you exercise? ☐ Yes ☐ No
If yes, what do you do and how often:

Activity	Frequency (daily? weekly?)	Duration (# of minutes)

Do you wear a seat belt? ☐Yes ☐No
Do you wear a helmet when biking or skateboarding? ☐Yes ☐No
Do you feel safe in your home? ☐ Yes ☐ No
Have you ever been a victim of violence? ☐ Yes ☐ No
Are you afraid that someone might hurt you? ☐ Yes ☐ No
Are you afraid that you might hurt yourself or others? ☐ Yes ☐ No

Please identify your *current/ recent* Signs and Symptoms:

General

__Poor appetite __Heavy appetite __Poor sleep __Heavy sleep
__Insomnia __Fatigue __Tremors __Vertigo
__Cold hands __Cold Feet __Cold back __Cold abdomen
__Fevers __Chills __Night sweats __Sweat easily
__Cravings __Localized weakness __Poor coordination __Change in appetite
__Sudden energy drop at_____(time) __Peculiar taste/s _____
__Strong thirst (cold/hot drinks)_____ __Bleed or bruise easily (where?)_____

Notes:_____

Skin and Hair

__Rashes __Ulcerations __Hives __Itching
__ Eczema __Pimples __Dandruff __Loss of hair
__Change in hair/skin texture __Purpura (hives) __Psoriasis
__Other hair or skin problems_____ __ Lumps or bumps of concern

Notes:_____

Head, Eyes, Ears, Nose, and Throat

__Dizziness __Concussions __Migraines __Glasses/contact lenses
__Eyestrain __Eye pain __Poor vision __Night blindness
__Color blindness __Cataracts __Blurry vision __Earaches
__Ringing in ears __Poor hearing __Nose bleeds __Sinus Problems
__Mucus __Dry throat __Dry mouth __Copious Saliva
__Teeth problems __Jaw clicks __Grinding teeth __Facial pain
__Gum problems __Spots in eyes __Recurrent sore throats __Dry eyes
__Sores on lips or tongue __Headaches (where and when)_____
__Other head or neck problems _____

Notes:_____

Cardiovascular

__High blood pressure __Low blood pressure __High cholesterol __Irregular heartbeat
__Dizziness __Fainting __Cold hands/feet __Swelling in hands/feet
__Blood clots __Chest pain __Phlebitis __Difficulty breathing
__Other cardiovascular problems? _____

Notes:_____

Respiratory

__Cough __Coughing blood __Asthma __Bronchitis
__Pneumonia __Tight chest __Difficulty breathing while lying down
Any persistent production of phlegm? _____ What color? _____
__Other lung problems?_____
*Notes:*_____

Gastrointestinal

__Nausea __Vomiting __Heartburn/Indigestion __Diarrhea __Belching
__Black stools __Bad breath __Rectal pain __Hemorrhoids __Gas
__Constipation __Bloody stools __Sensitive abdomen __Pain or cramps
Do you regularly use laxatives? _____How often? _____
Do you regularly use antacids?_____ How often? _____
Please describe your bowel movements: color_____
odor_____
texture/form_____
frequency_____

Notes:_____

Genitourinary

__Pain on urination __Frequent urination __Blood in urine __Urgency to urinate
__Unable to hold urine __Kidney stones __Venereal disease __Impotency
__Enlarged prostate __Genital sores

__Do you get up to urinate overnight?_____ How frequently? _____ What time? _____
__Other urinary tract problems_____

Notes:_____

Gynecology and Pregnancy:

Age at first menses_____ Last menses (date)_____ Frequency of periods _____
Period duration: ____days Irregular periods_____ Flow (light, medium, heavy) _____ Clots_____
Pain with periods _____
Any changes in body/psyche prior to each menstruation?_____
Do you do Breast Self Exam? Y/N Breast lumps/cyst_____
Vaginal soreness_____ Vaginal discharge? (describe) _____ Last PAP (date, +/-)_____
Birth control? Y/N Type _____ Since when? _____
No. of pregnancies ___ No. of deliveries ___ No. of miscarriages ___ No. of abortions ___
Menopause (approximate date of onset) _____
Changes in body/psyche post menopause? _____

Other thoughts? _____

Neuropsychological

__Seizures __Areas of numbness/tingling __Poor memory
__Poor balance __Anxiety __Concussion
__Depression __Easily stressed __Bad temper

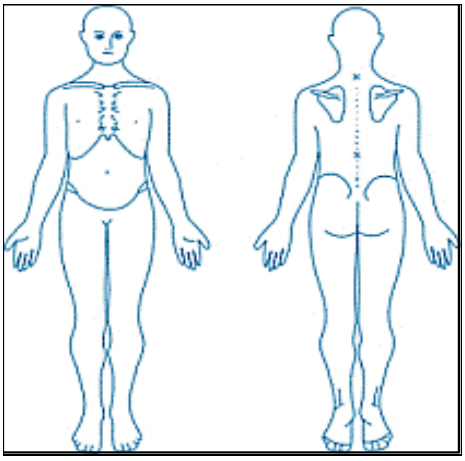
Have you ever had an eating disorder)? _____
Please describe: _____
Have you considered or attempted suicide? _____
Have you ever been treated for psychological problems or substance abuse? _____
Other neurological or psychological problems:_____
Notes:_____

Muscle/Joint/Bone

Do you experience pain, weakness or numbness in your (check and circle Right and/or Left):
__Arms (R/L) __ Hands (R/L) __Shoulders (R/L) __Neck __ Back
__Knees(R/L) __Feet (R/L) __Hips (R/L)
__Other, please specify: _____
_____
Does pain affect your daily activities? If yes, please describe _____
_____
_____
_____

On a scale from 1 (least) to 10 (most), how intense is your pain currently? _____
Do you have any other joint or bone problems? _____

In the figure to the right, please mark areas of discomfort.



Prescription and over-the-counter medications currently taking:

Name of Medication	Dosage/Frequency	Date Started	Condition being addressed

Nutritional supplements (include vitamins, homeopathic remedies, medicinal herbs):

Name of Supplement	Dosage/Frequency	Date Started	Condition being addressed