Canyon Medical Center

2100 SW Camelot Ct
Portland, OR 97225
P: (503) 252-8125
F: (503) 256-8422
info@canyonmedcenter.com
www.canyonmedcenter.com

ADULT INTAKE

Legal Name: _____ Date: _____

Name I preferred to be called, if different: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home): _____(cell)_____ (work): _____

Email address: _____ Skype name: _____

Age: _____ Date of Birth: _____ Sexual Orientation Identity: _____ Preferred Pronoun: _____

Gender: Female / Male / Transgender Relationship Status: _____

Living Status: Spouse or Partner / Parents / Children / Friends / Alone / Other: _____

Height: _____Weight: _____Weight one year ago: _____Max. Weight: _____When: _____

Occupation: _____ Hours per week: _____

Employer Name and Address: _____

Education:_____

Emergency contact: _____ Relationship: _____

Address: _____

_____ Phone: _____

How did you hear about this clinic?

Another practitioner_____ Friend/family member Google search Facebook ad

Radio ad Brochure Women to Women Public health talk

Health fair ND directory_____ ND school Professional seminar Other_____

Has any other family member already been a patient at this clinic? _____

ALLERGIES

Are you hypersensitive or allergic to:

Drugs? _____

Foods? _____

Environmental or chemical? _____

CURRENT CONDITIONS

Do you have any known contagious diseases or conditions at this time? Yes / No

If yes, what? _____

_____

Are you currently receiving healthcare? Yes / No If yes, where and from whom? _____

_____

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PT DOB: _____

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If no, when and where did you last receive medical or health care? _____

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

CHILDHOOD ILLNESSES

Birth city & state: _____Birth time: _____ Birth weight:_____

Please circle whether you had any of the following as a child:

Rheumatic fever	Diphtheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Any other relevant family history? _____

What is your family heritage? _____

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies: _____

Exercise: Y / N If so, what kind and how often: _____

Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? _____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

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CURRENT MEDICATIONS/SUPPLEMENTS

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid Medication
Birth Control Pills	Hormone Replacement		

Please list any others:

Medication	Dosage	Frequency

Supplement	Dosage	Frequency

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

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What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?

What *long-term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and adhering to the therapeutic protocols that we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

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STRESS EVALUATION FORM

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

When I am stressed, it is often…

- **EMOTIONAL—**anger, irritability, anxiety, frustration, or depression
  _____
- **ENVIRONMENTAL—**noise, crowds, air quality, scents, colors, light, temperature
  _____
- **PHYSICAL—**work, exercise, diet, pain, relaxation, disease, addiction
  _____
- **ALLERGENS OR SENSTIVITIES—**please list
  _____

Is your stress?

- **Acute** (arisen within a month)
- **Chronic** (experiencing for a month or more)
- **Both-**explain: _____
  _____

How do you tend to feel when you're stressed?

- Over-excited—angry, agitated and/or keyed up. Other: _____
- Under-excited—depressed, withdrawn, reserved, tired, underwhelmed and/or spaced-out. Other: _____
- Frozen—unable to respond. Other: _____
- A combination of them all

How is your body affected when you are stressed?

- Neck/Shoulders/Back
- Joints
- Stomach/Gut/Bowels
- Headaches
- Breakout/Skin Conditions
- Insomnia or other disrupted sleep patterns
- OTHER: _____

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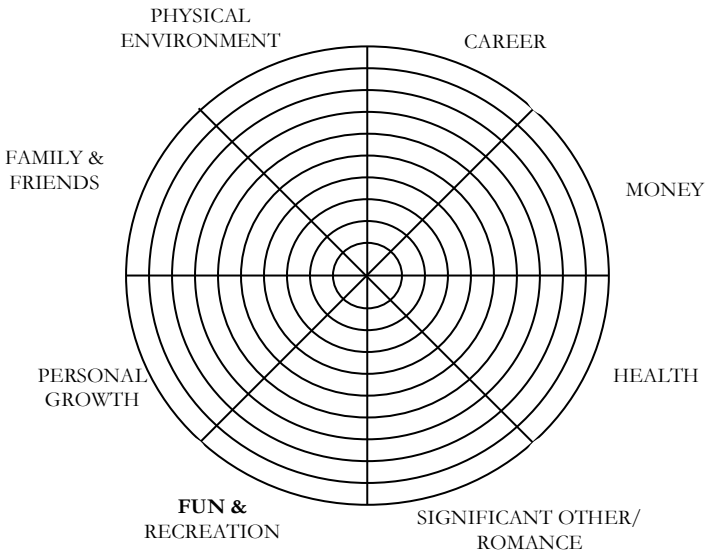
WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have currently **N**=no/never had **P**= problem in the past **S**=sometimes a problem now

GENERAL

Do you sleep well?	Y	N	P	S
Average 6-8 hours?	Y	N	P	S
Awake rested?	Y	N	P	S
In a supportive relationship?	Y	N	P	S
Have a history of abuse?	Y	N	P	S
Experienced major trauma?	Y	N	P	S
Use recreational drugs?	Y	N	P	S
Treated for drug dependence?	Y	N	P	S
Use alcoholic beverages?	Y	N	P	S
Use tobacco?	Y	N	P	S
If in the past, how many years? _____				
How many packs per day? _____				
Do you enjoy your work?	Y	N	P	S
Take vacations?	Y	N	P	S
Spend time outside?	Y	N	P	S
Eat three meals a day?	Y	N	P	S
Do you go on diets often?	Y	N	P	S
Do you eat out often?	Y	N	P	S
Do you drink coffee?	Y	N	P	S
Drink black/green tea?	Y	N	P	S
Drink soda?	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S
Do you add salt to your food?	Y	N	P	S

NEUROLOGICAL

Seizures?	Y	N	P	S
Muscle weakness?	Y	N	P	S
Loss of memory?	Y	N	P	S
Vertigo or dizziness?	Y	N	P	S
Paralysis?	Y	N	P	S
Numbness or tingling?	Y	N	P	S
Easily stressed?	Y	N	P	S
Loss of balance?	Y	N	P	S

ENDOCRINE

Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S
Excessive thirst?	Y	N	P	S
Fatigue?	Y	N	P	S
Heat or cold intolerance?	Y	N	P	S
Hyperthyroid?	Y	N	P	S
Diabetes?	Y	N	P	S
Excessive hunger?	Y	N	P	S
Seasonal depression?	Y	N	P	S
Difficulty exercising?	Y	N	P	S

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IMMUNE

Reactions to immunizations?	Y	N	P	S
Chronically swollen glands?	Y	N	P	S
Slow wound healing?	Y	N	P	S
Chronic fatigue syndrome?	Y	N	P	S
Chronic infections?	Y	N	P	S
Night sweats?	Y	N	P	S

EARS

Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Ear aches?	Y	N	P	S

EYES

Impaired vision?	Y	N	P	S
Cataracts?	Y	N	P	S
Glaucoma?	Y	N	P	S
Spots in vision?	Y	N	P	S
Color blindness?	Y	N	P	S
Tearing or dryness?	Y	N	P	S
Eye pain or strain?	Y	N	P	S

HEAD

Headaches?	Y	N	P	S
Migraines?	Y	N	P	S
Head injury?	Y	N	P	S
Jaw or TMJ problems?	Y	N	P	S

NOSE AND SINUS

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

NECK

Lumps in neck?	Y	N	P	S
Goiter?	Y	N	P	S
Difficulty swallowing?	Y	N	P	S
Pain or stiffness in neck?	Y	N	P	S

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S

MOUTH AND THROAT, cont.

Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S

RESPIRATORY

Cough?	Y	N	P	S
Sputum?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Shortness of breath when lying down?	Y	N	P	S
Pain with/when breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S

SKIN

Rashes?	Y	N	P	S
Acne/boils?	Y	N	P	S
Change in skin color?	Y	N	P	S
Lumps or bumps on skin?	Y	N	P	S
Eczema or hives?	Y	N	P	S
Itching?	Y	N	P	S
Perpetual hair loss?	Y	N	P	S

GASTROINTESTINAL

Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain/cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S

Bowel movements: how often? _____
Is this a change?_____

Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S

URINARY

Frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S

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URINARY, cont.

Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S

MENTAL/EMOTIONAL

Treated for emotional issues?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms/cramps?	Y	N	P	S
Sciatica?	Y	N	P	S

BLOOD

Anemia?	Y	N	P	S
Easy bleeding or bruising?	Y	N	P	S
Cold hands/feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S

FEMALE REPRODUCTIVE

Age of first menses: _____
Age of last menses (if menopausal):_____
Length of cycle: _____days
Duration of menses: _____days

Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S

Symptoms:_____
_____

Bleeding between cycles?	Y	N	P	S

FEMALE REPRODUCTIVE, cont.

Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S

Date of last pap smear: _____

Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Are you sexually active?	Y	N	P	S

Birth control? Type: _____

Pain during intercourse?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S

Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____

Do you do self breast exams?	Y	N	P	S
Breast pain/tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P	S

Birth control? Type: _____

Discharge or sores?	Y	N	P	S
Premature ejaculation?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S