Natural Choices Health Clinic

Your natural choice for health care

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Dr. Keivan Jinnah, ND, MSOM, LAc

Legal Name: _____ Date of First Visit: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (Home) _____ (Work) _____ (Cell) _____

Best number for contacting or leaving messages (H/W/C): _____

E-mail address: _____

Date of Birth: _____ Age: _____ Sex: _____

Place of Birth: _____ Time of birth (if known): _____

Married ____ Widowed ____ Single ____ Partnership ____

Live with: Self ___ Spouse___ Partner ___ Parents ___ Children ___ Friends___

Occupation: _____ Hours per week: _____ Retired: _____

Employer: _____

Work address: _____

How did you hear about our clinic: _____

Has any other family member been a patient at our clinic: _____

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

Relationship: _____ Phone: _____

Address: _____

Context of Care Overview

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient. 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?

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 physician?

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, with 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? (Please list)

What behaviors of lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits? (Please list)

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

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

Are you currently receiving healthcare? Y N
If yes, where and from whom? _____

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

Do you have any contagious diseases at this time? Y N
If yes, what? _____

General

Height_____ Weight _____lbs. Weight 1 year ago _____lbs.
Maximum weight _____ When? _____

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

Current Medications

Do you take or use any of the following:

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Antibiotics	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N	Sleeping pills	Y	N

Hospitalizations, Surgeries, Imaging

What hospitalizations or surgeries, X-rays, CAT Scans, EEG, EKG's have you had?

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

Childhood Health

How was your health as a child? Any major illnesses? :_____
_____
_____

Have you had many rounds of antibiotics in your life? How often? :_____
_____
_____

Family History

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

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hayfever/Hives			

Any other relevant family history? _____
_____
What is your heritage? _____

Allergies

Are you hypersensitive or allergic to…
Any drugs? _____
Any foods? _____
Any environmental or chemicals? _____

Habits

FOR THE FOLLOWING, PLEASE CIRCLE
Y= a condition you *have now* **N**= never had **P**= significant problem in the past

Main interests and hobbies?_____
Do you exercise? Y N
If yes, what kind?_____
How many times a week do you exercise? _____

Average 7-9 hrs. sleep? Y N
Sleep well? Y N
Awaken rested? Y N
Have a supportive relationship? Y N
Have a history of abuse? Y N
Any major traumas? Y N P
Use recreational drugs? Y N P
Been treated for drug dependence? Y N P
Drink alcohol? Y N P
How many alcoholic beverages do you drink per week?_____
Treated for alcoholism? Y N P
Do you smoke? Y N P
How many packs a day? _____
Smoked previously? Y N P
How many years? _____
How many packs per day?_____

Enjoy your work? Y N
Take vacations? Y N
Spend time outside? Y N
Watch television? Y N
how many hours? _____
Read?
how many hours? _____
Do you eat 3 meals a day? Y N
Do you go on diets often? Y N P
Do you drink cola/sodas? Y N P
Do you eat refined sugar? Y N P
Do you add salt? Y N P
Do you drink coffee? Y N P
How many cups per day? _____
Do you drink tea (black or green)? Y N P
How many cups per day? _____
What is your water intake per day? _____

Have there been any events/surgeries/accidents/traumas in your life that you feel have negatively affected your health? I.e. "I've never been well since…" If yes, please briefly describe, including how old you were at the time:

_____
_____
_____
_____
_____