Amber Wellness Group, PLLC 1944 NE 45th Portland, OR 97213

NEW PATIENT INFORMATION

Please complete the document as thoroughly and legibly as possible. Some of the questions that follow may seem unrelated to your condition, but the may play a major role in diagnosis and treatment.

Today's Date: _____

Print Name: _____ Preferred Name: _____

Street Address: _____

City, State, Zip: _____

CellPhone: _____ Home Phone: _____Work Phone: _____

Email: _____Would you like receive AWG email newsletter? ☐ Yes ☐ No

Occupation: _____ Employer: _____

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated Preferred Pronoun: _____

Name of Spouse / partner: _____ Phone Number: _____

If patient is under 18, please list guardian and their relationship to patient: _____

Emergency Contact: _____Phone Number: _____

☐ same as spouse / partner

Age: _____ Date of Birth: _____/_____/_____ Height ____' _____" Weight _____# (Current) _____# (Past max)

How did you hear about us or who may we thank for referring you? _____

Name of your primary care physician? _____ Phone #: _____

Please list other practitioners that you have seen for your health concerns:

1. Name: _____ Phone #: _____
2. Name: _____ Phone #: _____
3. Name: _____ Phone #: _____

Please list any prescription, supplement or over the counter medication you are currently taking.

Medication OR Supplement	For?	Dosage	Medication Or Supplement	For?	Dosage

What is your primary health concern? _____

When did this problem Begin? _____

What makes it better or worse? _____

Has this condition been evaluated by any other physician? _____ If so, please list any known diagnosis. _____

What prior treatments have you had for this condition and what were the results? _____

_____

Does this impair your daily activities? ☐ Y ☐ N restriction: _____

_____

Please list any other health concerns that you wish to address:

1. _____ 3. _____
2. _____ 4. _____

Please provide complete information in the following pages related to your current and past health concerns.

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
Allergies	☐	☐	STI's	☐	☐	Mononucleosis	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Multiple Sclerosis	☐	☐
Blood Pressure High	☐	☐	Hepatitis	☐	☐	Mumps	☐	☐
Blood Pressure Low	☐	☐	Herpes virus	☐	☐	Pneumonia	☐	☐
Bruise Easily	☐	☐	High Fever	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	HIV	☐	☐	Thyroid Disorder	☐	☐
Chicken Pox	☐	☐	Jaundice	☐	☐	Tubercolosis	☐	☐
Diabetes	☐	☐	Lyme's Disease	☐	☐	Other:	☐	☐
Emphysema	☐	☐	Measles	☐	☐		☐	☐
Epilepsy	☐	☐	Meningitis	☐	☐		☐	☐
Glaucoma	☐	☐	Migraines	☐	☐		☐	☐

Recent Medical Tests:

Test:	Date:	Results:	Test:	Date:	Results:
Physical			Pap Smear:		
Cholesterol:			HIV/STD:		
Prostate:			Blood Sugar:		
Mammogram:			Thyroid:		
Other:			Other:		

List any food allergies, sensitivities or intolerances and your reaction: _____

List any allergies related to medications or supplements and your reaction: _____

List any prior surgeries and what they were for and the date or approximate date / year performed:

1. Type: _____ Reason: _____ Date: _____
2. Type: _____ Reason: _____ Date: _____
3. Type: _____ Reason: _____ Date: _____

Please indicate family history of: ☐ Cancer ☐ Heart Disease ☐ Thyroid ☐ Diabetes ☐ Endocrine ☐ Infertility ☐ Allergies ☐ Auto-immune Disease ☐ High Blood Pressure ☐ High cholesterol ☐ Other _____
Please Indicate any addictions to: ☐ Nicotine ☐ Prescription Medication ☐ Alcohol ☐ Other: _____

Energy, Emotions and Immunity

☐ Fatigue	☐ Slow Wound Healing	☐ Easy to catch Colds	☐ Chronic Fatigue Syndrome
☐ Low Energy ____/10	☐ Stress Level _____/10	☐ Mood Swings	☐Anxious / Nervous
☐ Mental Tension	☐ Joy	☐ Worry	☐ Fear
☐Irritable	☐Anger	☐ Grief	☐ Depression
☐ Overwhelmed	☐ Overworked	☐ Mental Fogginess	☐ Cold Hands/Feet
☐ Suicidal Thoughts	☐ Panic Attacks		

Sleep:

☐ Restless	☐ Non-restful	☐ Busy Mind	☐ Night Sweats
☐ Difficult to fall asleep	☐ Difficult to stay asleep	☐ Nightmares	☐ Vivid Dreaming
☐ Awaken to urinate	☐ Awaken with pain	☐ Number of hours of sleep per night: _____	

Head, Eye, Ear, Nose, Throat:

☐ Impaired Vision	☐ Eye pain / strain	☐ Glaucoma	☐ Tearing / Dryness
☐ Impaired Hearing	☐ Ear Ringing	☐ Earaches	☐ Swollen Glands
☐ Headaches	☐ Migraines	☐ Allergies	☐ Frequent Sore Throats
☐ Sinus Problems	☐ Nasal Discharge	☐ Nose Bleeds	☐ Teeth Grinding / TMJ
☐ Sores on tip of tongue	☐ Gum Disease	☐ Teeth Problems	☐ Dry Mouth

Respiratory:

☐ Cough	☐ Shortness of Breath	☐ Pneumonia	☐ Pleurisy
☐ Smoking History and #/Day	☐ Current _____	☐ Past _____	☐ Asthma

Skin:

☐ Rash	☐ Eczema	☐ Psoriasis	☐ Itchy Skin
☐ Dry Skin	☐ Hives	☐ Acne	☐ Dandruff

Cardiovascular:

☐ Heart Disease	☐ Chest Pain	☐ Swelling of ankles	☐ Heart Murmurs
☐ High Blood Pressure	☐ Palpitations / Fluttering	☐ Poor Circulation	☐ Varicose Veins

Gastrointestinal:

☐ Nausea / Vomiting	☐ Heartburn	☐ Belching / Gas	☐ Blood in Stool
☐ Undigested Food in Stool	☐ Gurgling in Stomach	☐ Fatigue after Eating	☐ Mucous in Stool
☐ Ulcers	☐ Incomplete Stools	☐ Bloating	☐ Abdominal Pain
☐ Diarrhea	☐ Constipation	☐ Gall Bladder Disease	☐ Liver Disease
☐ Hemorrhoids	☐ Hernia	☐ Food Cravings: _____	

Genito-Urinary Tract:

☐ Painful Urination	☐ Frequent Urination	☐ Blood in Urine	☐ Frequent Urination at Night
☐ Frequent UTI	☐ Impaired Urination	☐Kidney Stones	☐ Kidney Disease
☐ Incontinence	☐ Urgent Urination	☐ Painful Intercourse	☐ Sexually Transmitted Infxn

Endocrine:

☐ Hypothyroid	☐ Hypoglycemia	☐ Hyperthyroid	☐ Diabetes Mellitus
☐ Feel Hot	☐ Feel Cold	☐ Low Libido	☐ Hair Loss

Neurological:

☐ Vertigo / Dizziness	☐ Numbness / Tingling	☐ Loss of Balance	☐ Paralysis

Pain:

☐ Neck / Shoulder	☐ Low Back	☐ Upper / Mid Back	☐ Arm
☐ Muscle Spasms / Cramps	☐ Leg	☐ Bone	☐ Arthritis
☐ Tendonitis	☐ Swollen Joints	☐ Sharp Pain	☐ Moving Pain
☐ Dull	☐ Achy	☐ Radiating Pain	☐ Burning

What Makes Pain Better:

☐ Soft Pressure	☐ Hard Pressure	☐ Heat	☐ Cold
☐ Rest	☐ Activity	☐ Other: _____	

What Makes Pain Worse:

☐ Pressure	☐ Heat	☐ Cold	☐ Activity
☐ Standing / Sitting to Long	☐ Rest	☐ Other: _____	

Please Rate your Pain:

Current	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Best	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Worst	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

No Pain **Mild** **Moderate** **Severe** **Intolerable**

Male Reproductive *

☐ Testicular Pain / Swelling	☐ Prostate Problems	☐ Sexual Difficulties	☐ Penile Discharge

Female Reproductive *

☐ Irregular Cycles	☐ Amenorrhea (no periods)	☐ Painful Periods	☐ PMS
☐ Bleeding Between Cycles	☐ Light Flow	☐ Heavy Flow	☐ Clotting
☐ Vaginal Itching / Burning	☐ Vaginal Discharge	☐ Sores on genitalia	☐ Vulvadynia
☐ Breast Lumps / Tenderness	☐ Menopausal Symptoms	☐ Nipple Discharge	☐ Painful Intercourse

Are you currently pregnant? ☐ No ☐ Yes, Please list due date: _____
Are you currently taking hormonal birth control? ? ☐ No ☐ Yes, Please list medication: _____

* If you are seeing us for preconception counseling or infertility concerns, please make sure you fill out our separate questionnaire.

Habits/Lifestyle:

Exercise: _____ times/week ☐ mild ☐ moderate ☐ IntenseText
Work Activity: ☐ Sitting ☐ Standing ☐ Computer
☐ Light Labor ☐ Heavy Labor # hrs/wk _____
Do you Enjoy Your Work? ? ☐ No ☐ Yes
Stress Level? ☐ None ☐ Mild ☐ Medium ☐ High
Spiritual Practice? ☐ No ☐ Yes _____
Have you experienced any major traumas? ☐ No ☐ Yes
Please Explain: _____

Hobbies: _____
Water: ☐ No ☐ Yes – # a day? _____
Alcohol: ☐ No ☐ Yes – # a day? _____ week? _____
Caffeine: ☐ No ☐ Yes – # a day? _____
Tobacco: ☐ No ☐ Yes – # a day? _____
Tevision: ☐ No ☐ Yes – # hours a day? _____
Reading ? ☐ No ☐ Yes – How many hours a day? ____

Typical Daily Food Menu:

Breakfast:	Lunch:	Dinner:	Snacks:	Drinks: