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

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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 they may play a major role in diagnosis and treatment.

Print Name _____ Preferred Name _____

Cell Phone _____ Home Phone_____ Work Phone _____

Street Address:_____

City, State, Zip: _____

Email: _____Would you like to receive AWG email newsletter? _____

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

Occupation: _____ Employer: _____

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

Emergency Contact: _____ Phone: _____ Relationship: _____

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 prescriptions, supplements, or over the counter medications you are currently taking:

Medication or Supplement	For?	Dosage	Medication or Supplement	For?	Dosage

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What is your primary health concern? _____

When did this problem begin? _____

What makes it better or worse? _____

Has this condition been evaluated by another physician? _____ If so, list any known diagnosis: _____

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

_____

Does this impair your daily activities? _____ If so, how? _____

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

1. _____
2. _____
3. _____
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			Heart Disease			Mononucleosis		
Asthma			Hepatitis			Multiple Sclerosis		
Blood Pressure			Herpes Virus			Pneumonia		
Bruise Easily			High Fever			Rheumatic Fever		
Cancer			HIV			STI's		
Chicken Pox			Jaundice			Thyroid Disorder		
Diabetes			Lyme Disease			Tuberculosis		
Emphysema			Measles			Other:		
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 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: _____

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FAMILY HISTORY

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 Medications ☐ Alcohol ☐ Other: _____

HEALTH CONCERNS

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	☐ Busy Mind	☐ Night Sweats	☐ Nightmares
☐ Difficult to fall asleep	☐ Difficult to stay asleep	☐ Vivid Dreaming	☐ Awake 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
☐ Tobacco Use Current	☐ Tobacco Use 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
☐ Gurgling in Stomach	☐ Undigested Food in Stool	☐ Fatigue after Eating	☐ Mucous in Stool
☐ Ulcers	☐ Incomplete Stools	☐ Bloating	☐ Abdominal Pain
☐ Diarrhea	☐ Constipation	☐ Gallbladder Disease	☐ Liver Disease
☐ Hemorrhoids	☐ Hernia	☐ Food Cravings: _____	

Genito-Urinary Tract:

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

Endocrine:

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

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

Musculoskeletal:
☐ Low Back Pain ☐ Neck / Shoulder Pain ☐ Mid Back Pain ☐ Arm Pain
☐ Leg Pain ☐ Muscle Spasms / Cramps ☐ Arthritis ☐ Tendonitis
☐ Other Pain: _____

Female Reproductive:
☐ Irregular Cycles ☐ Amenorrhea (no periods) ☐ Painful Periods ☐ PMS
☐ Light Flow ☐ Heavy Flow ☐ Clotting ☐ Bleeding Between Cycles
☐ Vaginal Itching ☐ Vaginal Discharge ☐ Sores on Genitalia ☐ Vulvadynia
☐ Nipple Discharge ☐ Breast Lumps / Tenderness ☐ Menopausal Symptoms ☐ Other: _____
☐ # Pregnancies _____ ☐ # Miscarriages _____ ☐ # Live Births _____ ☐ Birth Complications: _____

_____

Are you currently pregnant? ☐ No ☐ Yes, Please list due date: _____

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

Are you interested in learning more about the various pelvic floor rehabilitation therapies that we offer (trigger point therapy, Holistic Pelvic Care ™, and THERMIva)? ☐ Yes, please tell me more ☐ Not at this time

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

Male Reproductive:
☐ Prostate Problems ☐ Testicular Pain / Swelling ☐ Sexual Difficulties ☐ Penile Discharge

Habits / Lifestyle:
Exercise: _____ times/week ☐ Mild ☐ Moderate ☐ Intense
Work Activity: ☐ Sitting ☐ Standing ☐ Computer
☐ Light Labor ☐ Heavy Labor # hours/week _____
Do you enjoy your work? ☐ No ☐ Yes
Stress Level: ☐ Mild ☐ Medium ☐ High
Spiritual Practice: ☐ No ☐ Yes _____
Have you experienced any major traumas? ☐ No ☐ Yes
Please Explain: _____

Hobbies: _____
Water: Cups/day: _____
Alcohol: ☐ No ☐ Yes, #/day _____; week? _____
Caffeine: ☐ No ☐ Yes, #/day _____
Tobacco: ☐ No ☐ Yes, #/day _____
Television: ☐ No ☐ Yes, # hours a day _____
Reading: ☐ No ☐ Yes, # hours a day _____

Typical Daily Food Menu:

Breakfast:	**Lunch:**	**Dinner:**	**Snacks:**	**Beverages:**

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

_____

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

_____