Absolute Health
MEDICAL CENTER

DR. JUSTIN MORSE ND
NATUROPATHIC DOCTOR
MorseND@gmail.com
1755 Coburg Rd
Eugene, Or 97401

Health Intake Form

Name _____ Date of First Visit _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home)_____ (work) _____

Age _____ Date of Birth _____ Gender: female ____ male ____

Education _____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ Partnership _____

Live with: Spouse _____ Partner _____ Parents _____ Children ____ Friends _____ Alone _____

Occupation _____ Hours per week _____ Retired _____

Employer _____ S.S.# _____

(Work address) _____

Health insurance co. name and address _____

Telephone number (___)_____ Policy/Group # _____

Policy holder's name _____ Employer _____

Identification/Social Security # _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____
Next of Kin or other to reach in an emergency _____
Relationship _____ Phone _____

Address _____

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PLEASE FILL OUT BOTH SIDES OF EACH PAGE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

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? _____

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

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

Do you have any known contagious diseases at this time? Y N

If yes, what?_____

FAMILY HISTORY

	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILD
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good P=poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____
Check (√) those applicable						
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____

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	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILD
Asthma/Hayfever/Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Allergies

Are you hypersensitive or allergic to...
Any drugs? _____
Any foods? _____
Any environmentals? _____

For all the following sections,

Y = a condition you have now **N** = never had **P** = a condition you have had before

Childhood Illnesses

Scarlet fever	Y N P	Diphtheria	Y N P	Rheumatic fever	Y N P
Mumps	Y N P	Measles	Y N P	German measles	Y N P

Hospitalization and Surgery

What hospitalizations or surgeries have you had?

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

X-Rays and Special Studies

X-rays, CAT scans, or other studies you have had:

_____
_____

Electrocardiogram	Y N	Electroencephalogram	Y N

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other _____	

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N

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Tranquilizers Y N Thyroid medication Y N Sleeping pills Y N

Please list **any** prescription ***medications***, over the counter medications, ***vitamins*** or other ***supplements*** you are taking. Please list dose as well.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

HABITS

Main interests and hobbies?_____
Do you exercise? Y N
If yes, what kind?_____ How often? _____

Average 6-8 hrs. sleep?	Y		N	Enjoy your work?	Y	N
Sleep well?	Y		N	Take vacations?	Y	N
Awaken rested?	Y		N	Spend time outside?	Y	N
Have a supportive relationship?	Y		N	Watch television?	Y	N
Have a history of abuse?	Y		N	how many hours? _____		
Any major traumas?	Y	P	N	Read?	Y	N
Use recreational drugs?	Y	P	N	how many hours? _____		
Been treated for drug dependence?	Y	P	N			
Do you eat three meals a day?	Y		N	Use alcoholic beverages?	Y P	N
Do you eat out often?	Y		N	Treated for alcoholism?	Y P	N
Do you go on diets often?	Y		N	Do you use tobacco?	Y P	N
Do you drink coffee?	Y	P	N	Smoked previously?	Y P	N
Do you drink black or green tea?	Y	P	N	how many years? _____		
Do you drink cola or other sodas?	Y	P	N	how many packs per day? _____		
Do you eat refined sugar?	Y	P	N			
Do you add salt?	Y	P	N			

Do you have a religious or spiritual practice? Y N If yes, what?_____

How does your condition affect you?_____
_____
_____

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What do you think is happening?_____

_____

_____

Why?_____

_____

_____

What do you feel needs to happen for you to get better?_____

_____

_____

What do you enjoy most in your life?_____

_____

_____

How much change are you willing to make at this time for improving your health?

MINIMAL SOME COMPLETE

Is there any information about your health you would like to add? _____

_____

_____

GENERAL

Weight _____ lbs. Weight 1 year ago _____ lbs.
Maximum Weight _____ When _____
Height _____
When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS
FOR THE FOLLOWING, PLEASE CIRCLE
Y = a condition you have now **N** = never had **P** = a condition you have had before

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Considered/Attempted suicide?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N

ENDOCRINE

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N

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Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

IMMUNE

Vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

NEUROLOGIC

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

SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N	Night Sweats?	Y P N

HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

NOSE AND SINUSES

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

MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

RESPIRATORY

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Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath?	Y P N
Shortness of breath at night?	Y P N	" " " " " "lying down?	Y P N
Tuberculosis?	Y P N		

CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles?	Y P N		

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel Movements: How often? _____	
Blood in stool?	Y P N	Is this a change?_____	
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

MALE REPRODUCTION

Hernias?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Venereal disease?	Y P N	Discharge or sores?	Y P N
Are you sexually active?	Y N	Chlamydia?	Y P N
Sexual orientation: _____		Gonorrhea?	Y P N
Impotence?	Y P N	Condyloma?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N
Birth control? Type? _____		Syphilis?	Y P N

FEMALE REPRODUCTION/BREASTS

Age of first menses? _____
Age of last mense? _____ Are cycles regular? Y N

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Length of cycle? _____ days
Duration of menses? _____ days
Painful menses? Y P N
Heavy or excessive flow? Y P N
PMS? Y P N
If yes, what are your symptoms?
_____
_____

Endometriosis? Y P N
Ovarian cysts? Y P N
Difficulty conceiving? Y P N
Cervical Dysplasia? Y P N
Sexual difficulties? Y P N
Gonorrhea? Y P N
Herpes? Y P N
Are you sexually active? Y N
Do you do breast self exams? Y P N
Breast pain/tenderness? Y P N

Bleeding between cycles? Y P N
Pain during intercourse? Y P N
Clotting? Y P N
Discharge? Y P N
Birth control? Y P N
What type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Menopausal symptoms? Y P N
Abnormal PAP? Y P N
Chlamydia? Y P N
Condyloma? Y P N
Syphilis? Y P N
Sexual orientation: _____
Breast lumps? Y P N
Nipple discharge? Y P N

MUSCULOSKELETAL

Joint pain or stiffness? Y P N
Broken bones? Y P N
Muscle spasms or cramps? Y P N

Arthritis? Y P N
Weakness? Y P N
Sciatica? Y P N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising? Y P N
Deep leg pain? Y P N
Varicose veins? Y P N

Anemia? Y P N
Cold hands/feet? Y P N
Thrombophlebitis? Y P N

Welcome! *We're glad to serve you!* *If you have any questions, please ask!*

Name_____Date_____