Kathleen Flewelling, ND
A Natural Path Integrated Healthcare Services
620 S. Holladay Dr. # 6 Seaside, OR 97138

Legal Name____Nickname_____________________________

Address:____ Primary Phone_________________________

City, State, Zip:____ Alternative Phone_______________________

Email_______________________________**Emergency Contact (Name and Phone)**________________________

Date of Birth________________Marital Status (circle one) Single Partnered Married Widowed Divorced

Occupation____________________________For how long?_________Highest level of education___________

Primary Care Provider (PCP) Information (Please select one of the following):

□ I wish to establish Primary Care with A Natural Path Integrated Healthcare Services.
□ I see A Natural Path for ancillary/adjunctive care only. My Primary Care
Physician (PCP) is: __________________________________ At (Clinic Name): ___________________________
□ I do not have a Primary Care Physician and do not wish to establish Primary Care with A Natural Path at this time.

What concerns would you like to address? Please indicate how long they have been going on.

1.____2.____
3.____4.____

What other health related issues have you had in the past? Please include hospitalizations and surgeries

Year/Condition_________________________________ Year/Condition_______________________________
Year/Condition_________________________________ Year/Condition_______________________________

Immunizations: Please mark if you have received the following vaccinations.

___Polio ___Chicken Pox ___Rubella ___TB ___Mumps ___Other
___Measles ___Diphtheria ___Smallpox ___Hepatitis ___Tetanus
___Rabies ___Flu/Influenza ___Meningococcus ___Whooping cough/Pertussis

Any history of reactions to vaccinations? Please explain if yes_______________________________________

How is your stress level? High_____Average_____Low____ Major stresses?_______________________________

Allergy to a Medication or Substance: Please list and mark one reaction	**Mild reaction X**	**Moderate Reaction X**	**Severe Reaction X**

Tobacco Use: Please mark one	**X**	
Never Smoker		
Former Smoker		When did you quit?
Current Smoker		Heavy or light?
Smokeless Tobacco Use		

Do you use now or in the past	**What type?**	**Amount each day?**
Alcohol		
Coffee/Black tea		
Soda/ Carbonated beverages		
Recreational Drugs		

Current Medications/ Supplements (Use separate sheet if necessary)	**Dosage and Frequency**

Flip form over to continue filling in the backside of this form

Family History

Please mark any illnesses that you have had yourself or that have occurred in any of your blood relatives.

Please circle S for self or F for family. If known, please indicate who and at what age the illness occurred.

Self (S) or Family (F)	Illness	Relationship	Self (S) or Family (F)	Illness	Relationship
S F	Diabetes		**S F**	Scarlet Fever	
S F	Thyroid Problems		**S F**	Alcoholism	
S F	High Blood Pressure		**S F**	Gout	
S F	Hemophilia		**S F**	Venereal Disease	
S F	Mental Illness		**S F**	Lung Disease	
S F	Stroke		**S F**	Heart Disease	
S F	Kidney Disease		**S F**	Tuberculosis	
S F	Asthma/Allergies		**S F**	Anemia	
S F	Cancer, type_____________		**S F**	Arthritis	
S F	AIDS		**S F**	Aneurysm	
S F	Drug Addiction		**S F**	Epilepsy/Seizures	
S F	Eating Disorder		**S F**	Glaucoma	

Symptoms: Mark symptoms you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joints

Pain, weakness, numbness in:
- ☐ Hips ☐ Arms
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling of ankles

Eye, Ear, Nose, Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus Problems
- ☐ Vision-flashes/halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Changes in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

Other_____________

Women only
- ☐ Abnormal Pap
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last Menstrual Period___________________________

Date of Last PAP __________________

Date of Last Mammogram____________

Are you pregnant?__________________

How many children?________________

Whom may we thank for this referral?_________________________________

Have you used alternative medicine in the past?__________________________For what?____________________