A WellSpring of Natural Health, PC

Person-Centered Health Care ◦ Natural Medicine for the Whole Family

Adult New Patient - Intake Forms

☐ Mitchell Bebel Stargrove, ND, LAc ☐ Lori Beth Stargrove, ND

Patient Name _____ Today's Date _____

Address _____

City _____ State _____ Zip Code _____

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

Email Address _____

Age _____ Gender identity _____ Ethnic/Ancestral origins _____

Birthdate _____ Birth Time _____ am/pm Birth Place _____

Relationship status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partnership ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___ Community ___

Occupation _____ Hours per week _____ Retired _____

Employer _____

Work Address _____

Who referred you to WellSpring? _____

Emergency Contact (next of kin or other) _____

Relationship _____ Phone # _____

Address _____

Primary Medical Insurance Co. _____ Policy/Group #_____

Telephone # _____ Address _____

Policy Holder's Name _____ Birthdate _____

Secondary Medical Insurance Co. _____ Policy/Group #_____

Telephone # _____ Address _____

Policy Holder's Name _____ Birthdate _____

Eligible for Medicare coverage/benefits? Yes ___ No ___ Health/Medical savings account? Yes ___ No ___

Health History Questionnaire

Safe, effective and individualized medical treatment and health care requires your clinician to understand you as a whole person in your real life context. 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 being treated by any health care or medical provider(s)? Yes ____ No ____

If yes, where and from whom? _____

_____

If no, when and where did you last receive medical treatment or health care? _____

_____

What was the reason? Did your condition resolve or is it ongoing? _____

_____

What is the full name, phone # and city of your Primary Care Physician? _____

_____

What are your most important health and medical concerns? List in order of importance.

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

Is your health: Excellent ____ Good ____ Average ____ Poor ____

Is your walking pace: Brisk ____ Average ____ Slow ____

Do you have any contagious diseases at this time? No ____ Yes ____

If yes, what?_____

What do you do to enhance your health? _____

What are your family, work and social supports and stressors? _____

How has your dysfunction and disease affected your life? _____

Did you experience any significant stresses, traumas, and/or accidents in the two years before your condition appeared? Please describe: _____

Who in your life deeply inspires you? _____

What relationships are challenging for you? How? _____

Why are you choosing to focus on improving your health now? _____

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Family History

☐ Check if you were adopted

	MOTHER			FATHER			
	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	Siblings
Age (if living)							
Health (**R**obust, **C**ompromised, **M**ixed)							
Age at death (if deceased)							
Cause of death							

Check those applicable:

Please highlight any significant recent changes.

Cancer							
Diabetes /hypoglycemia							
Heart disease							
High blood pressure							
Stroke							
Epilepsy							
Depression/anxiety							
Asthma/hayfever/hives							
Obesity							
Kidney disease							
Tuberculosis							
Chemical/pesticide exposure							
Dysfunctional family							
Sexual abuse/rape							
Addiction/alcoholism							
Violence							
Food deprivation							
Poverty							
Immigration							
War							

For the Following, Please Circle:
Y = Yes **N** = No

Childhood Illnesses

Scarlet fever	Y N	Chicken pox	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

Hospitalization and Surgery

What hospitalizations or surgeries have you had? When?

_____

_____

_____

_____

X-Rays, Imaging and Special Studies

X-ray	Y N	Thermography	Y N
MRI	Y N	Electrocardiogram/EKG	Y N
CT/CAT scan	Y N	Electroencephalogram/EEG	Y N
Mammography	Y N	Food sensitivity/intolerance testing	Y N

Immunizations

Diphtheria/Tetanus/Pertussis (DTaP)	Y N	Hepatitis A	Y N
Measles/Mumps/Rubella (MMR)	Y N	Hepatitis B	Y N
Chicken Pox/Varicella	Y N	Human Papillomavirus (HPV)	Y N
Polio	Y N	Meningococcal	Y N
Flu/Influenza	Y N	Pneumococcal/Pneumonia	Y N
Tetanus (alone)	Y N	Shingles/Herpes zoster	Y N
Other _____		Other _____	

Sensitivities/Reactions

Are you hypersensitive or reactive to…

Any medications/drugs? _____

Any foods? _____

Environmental and Climate stressors? _____

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Drugs, Medications, Nutrients, Herbs, Remedies

Which of these substances have you used or been prescribed?

Pain relievers	Y N	Anxiety medication	Y N	Laxative	Y N
Steroid	Y N	Antidepressant	Y N	Antacid	Y N
Anti-inflammatories	Y N	Thyroid medication	Y N	Statin drug	Y N
Sleeping aid	Y N	Hormone replacement	Y N	Antibiotics	Y N

Please list *any and all* prescription drugs, over-the-counter medications, nutrients, herbs or other remedies you are *currently* taking.

Medicines (Drug, vitamin, nutrient, herb, etc.)	How much? How often?	Prescribed by?	Since when?	Take regularly? Y/N

Medical Treatment Coordination and Health Care Collaboration

Do you fully inform your conventional and natural medicine practitioners of all the herbs, nutrients, remedies and drugs that you take? What do you share and with whom? Why? If not, what information do you withhold?

With which healthcare provider(s) do you have the most honest communication and respectful relationship?

Do your medical providers share information and collaborate with each other and you in shaping your medical treatment and health care? If so, how?

Do you have the resources and support to fully implement the health care and medical treatment recommended/ prescribed by the clinicians you see? If not, what are the limiting factors?

Typical Food and Drink Intake

Breakfast: _____

_____

_____

Lunch: _____

_____

_____

Dinner: _____

_____

_____

Between Meals: _____

_____

Liquids: _____

_____

Cravings: _____

_____

Household and Environmental Supports and Stressors

Where do you buy most of your groceries? _____

What household cleaners do you use? _____

What fertilizers, pesticides, weed killers do you use? _____

What shampoo do you use? _____

Do you use hair dye or coloring? _____

What toothpaste do you use? _____

Do you have mercury amalgam dental fillings? Removed? _____

Do you have mold in your home? Previously? _____

Are you sensitive to electromagnetic stressors? _____

General History

Weight _____ lb. Height _____ Vitality: high medium low

ABO Blood Type _____ FUT2 Secretor status _____

What time of the day is your energy the highest? _____ Lowest? _____

In broad terms, what are you health strengths and challenges? _____

_____

Review of Systems

For the Following, Please Circle:

Y = Current Condition **P** = Previous Condition **N** = Never

Relationships

Adoption	Y N	Divorce (parental)	Y N
Birth trauma	Y N	Sexual abuse	Y N
Familial alcoholism/addiction	Y N	Violence in family of origin	Y N

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

Hormones/Endocrine

Hypothyroid	Y P N	Heat or cold intolerance	Y P N
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
Adrenal stress	Y P N	Night sweats	Y P N

Immune/Lymphatic

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

Y = Current Condition **P** = Previous Condition **N** = Never

Brain/Nervous System

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
Hypersensitivity	Y P N	Concussion	Y P N

Skin/Hair

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 or thinning	Y P N
Lumps	Y P N	MRSA	Y P N

Head

Headaches	Y P N	Head injury	Y P N
Migraines	Y P N	Jaw/TMJ problems	Y P N

Eyes/Vision

Spots in vision	Y P N	Eye pain/strain	Y P N
Impaired or blurry vision	Y P N	Glasses or contacts	Y P N
Tearing or dryness	Y P N	Glaucoma	Y P N
Color blindness	Y P N	Macular degeneration	Y P N
Double vision	Y P N	Cataracts	Y P N

Ears/Hearing

Impaired hearing	Y P N	Ringing/Tinnitus	Y P N
Earaches	Y P N	Dizziness	Y P N

Nose and Sinuses

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

Y = Current Condition **P** = Previous Condition **N** = Never

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 clicking	Y P N

Neck

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

Respiratory

Cough	Y P N	Chronic phlegm	Y P N
Croup	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
Spitting up blood	Y P N	Shortness of breath on exertion	Y P N
Tuberculosis	Y P N	Shortness of breath at night	Y P N

Cardiovascular/Heart

Heart disease	Y P N	Angina	Y P N
High or low blood pressure	Y P N	Murmurs	Y P N
Blood clots	Y P N	Fainting	Y P N
Phlebitis	Y P N	Palpations/Fluttering	Y P N
Rheumatic Fever	Y P N	Chest pain	Y P N
Swelling in ankles	Y P N	Cold hands and/or feet	Y P N

Blood/Peripheral Vascular

Easy bleeding or bruising?	Y P N	Anemia	Y P N
Deep leg pain?	Y P N	Cold hands/feet	Y P N
Varicose veins?	Y P N	Thrombophlebitis	Y P N

Y = Current Condition **P** = Previous Condition **N** = Never

Gastrointestinal/Digestive

Trouble swallowing	Y P N	Heartburn/Reflux/GERD	Y P N
Change in thirst	Y P N	Hiatal hernia	Y P N
Nausea	Y P N	Vomiting	Y P N
Ulcer	Y P N	Bowel movements How often?	_____
Blood in stool	Y P N	Is this a change?	Y N
Black stools	Y P N	Urgency?	Y P N
Belching or passing gas	Y P N	Constipation	Y P N
Abdominal pain or cramps	Y P N	Diarrhea/Loose stools	Y P N
Jaundice	Y P N	Gall bladder problems	Y P N
Liver disease	Y P N	Hemorrhoids	Y P N
Gluten intolerance	Y P N		

Musculoskeletal

Neck pain or stiffness	Y P N	Muscle spasms or cramps	Y P N
Mid-back pain or stiffness	Y P N	Arthritis	Y P N
Low back/hip pain or stiffness	Y P N	Fibromyalgia	Y P N
Sciatica	Y P N	Broken bones	Y P N
Foot/ankle pain or stiffness	Y P N	Bursitis	Y P N
Knee pain or stiffness	Y P N	Tendinitis	Y P N

Urinary

Pain on urination	Y P N	Increased frequency	Y P N
Frequency at night	Y P N	Incontinence	Y P N
Frequent infections	Y P N	Kidney stones	Y P N

Male Sexual/Reproduction

Hernias	Y P N	Prostate disease	Y P N
Testicular pain	Y P N	Masturbation	Y P N
Testicular masses	Y P N	Reduced libido	Y P N
Are you sexually active?	Y P N	Discharge or sores	Y P N
Are you sexually satisfied?	Y P N	Chlamydia	Y P N
Sexual orientation:	_____	Herpes	Y P N
Impotence	Y P N	HPV/Venereal warts	Y P N
Premature ejaculation	Y P N	Gonorrhea	Y P N
Birth control	Y P N	Syphilis	Y P N

If so, what type? _____

Y = Current Condition **P** = Previous Condition **N** = Never

Female Sexual/Reproduction/Breasts

Age of first menses: _____
Date of last menses: _____
Length of menstrual 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
Breast pain/tenderness Y P N
Breast lumps Y P N
Nipple discharge Y P N
Do you do breast self-exams? Y P N
Sexual orientation: _____
Are you sexually satisfied? Y P N

Masturbation Y P N
Pain during intercourse? Y P N
Are cycles regular? Y P N
Bleeding between periods? Y P N
Clotting Y P N
Discharge Y P N
Birth control Y P N
What type? _____
Age of first use: _____
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
HPV/Venereal warts Y P N
Syphilis Y P N
Herpes Y P N

Any other health patterns or medical concerns? _____

Life Situation, Habits and Values

How does your current condition affect you? _____

What do you think is happening? Why? _____

What do you feel needs to happen for you heal? _____

Have you experienced major trauma? If so, please describe? _____

Main creative activities, interests and hobbies? _____

How do you exercise? How often? _____

What is your relationship to family, friends and community? _____

Do you have a religious faith or spiritual practice? Yes ____ No ____ If yes, what? _____

How do you nourish and cultivate yourself? _____

What is your relationship to the place where you live? _____

_____

_____

What do you know about your birth? _____

_____

_____

Have you made any plans for your dying? _____

_____

_____

What do you enjoy most in your life? _____

_____

_____

Eat three meals a day?	Y N	Read?	Y P N
Eat out often?	Y N	How many hours per day? _____	
Go on diets often?	Y N	Watch television?	Y P N
Cook meals at home?	Y N	How many hours per day? _____	
Drink coffee?	Y N	Use computer?	Y P N
Drink black tea?	Y N	How many hours per day? _____	
Drink cola or other soft drinks?	Y N	Gaming or internet overuse or addiction?	Y P N
Eat sugar or sweets?	Y N	Substance overuse or abuse?	Y P N
Add salt to food?	Y N	Recreational or entheogenic substance use?	Y P N
Have a supportive relationship?	Y N	Alcohol use or abuse?	Y P N
Enjoy your work?	Y N	How often? _____	
Take vacations?	Y N	Smoke or chew tobacco?	Y P N
Sleep well?	Y N	How much? _____	
Average 7-9 hrs. sleep?	Y N	Tobacco use or abuse?	Y P N
Awaken rested?	Y N	How many years? _____	
Spend much time outside?	Y N	How much? _____	

How much are you willing and able to make changes to improve your daily life?

MINIMAL SOME COMPLETE

Welcome to WellSpring! We are here to serve you.

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Directions to WellSpring ~ 4720 SW Watson Avenue, Beaverton

From South I- 5 or Tigard:

Take Interstate-5 to Hwy 217. Follow Hwy 217 North heading toward Beaverton. Take the **Allen Street Exit**. Turn left at the first stoplight, which is Allen Street. Go forward to the **third stoplight**, which is **Hall Boulevard**. Turn right onto Hall going North. After the stoplight at 5th Avenue, turn **left onto Third Avenue**. Go forward just short of **two blocks**. Our parking lot and building are located on the **right-hand side**. The clinic is on the Northeast corner of 3rd and Watson at 4720 SW Watson Avenue.

From Downtown Portland:

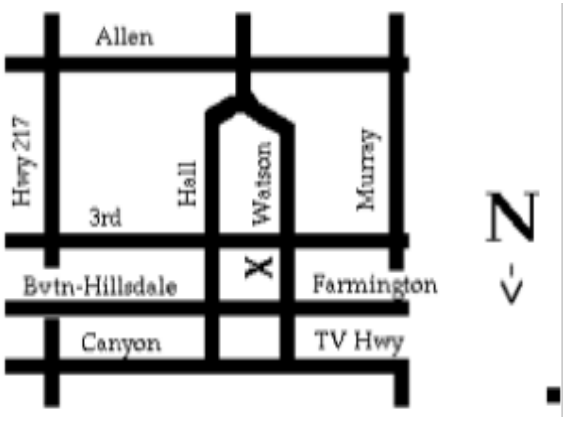
Take **Highway 26 West** to Highway 217 South. Follow Hwy 217 and take the **Beaverton-Canyon Road Exit** (Highways 8 and 10). Turn right at the **second stoplight**, which is **Beaverton-Hillsdale Highway**, and then becomes **Farmington Road** as you cross the railroad tracks. Go forward to the **fourth stoplight**, which is **Watson Avenue** (two blocks past Hall Blvd.). Turn left onto Watson. The clinic is located **three blocks down** on the left-hand side. We are on the left-hand (NE) corner, nearest you, of 3rd and Watson at 4720 SW Watson Avenue.

From SW Portland:

Take **Beaverton-Hillsdale Highway** west. After you pass underneath **Hwy 217**, go straight up to the **fifth stoplight**, which is **Watson Avenue**. Turn left onto Watson. The clinic is located **three blocks down** on the left-hand side. We are on the left-hand (NE) corner of **3rd and Watson** at 4720 SW Watson Avenue.

From Hillsboro or Aloha:

Take **Farmington Road** to downtown Beaverton. Turn right onto **Watson Avenue**. (If you have come to Hall Boulevard, you have gone two blocks too far.) The clinic is located **three blocks down on the left**-hand corner. We are on the left-hand (NE) corner of **3rd and Watson** at 4720 SW Watson Avenue.



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Communication Guidelines

These are some guidelines that can make our communication more effective:

1. When you call the office, leave a message with the receptionist including a detailed description of your concerns and/or questions and a few times during which you will be available to talk on the phone. This initial information will enable your clinician to make a preliminary determination about whether your needs can be adequately addressed on the phone or whether you need to make an in-person appointment or a telemedicine appointment.
2. If the doctor has not returned your call in what you feel is a reasonable amount of time, you may call again. Our ability to respond will be delayed in the event that you do not answer the phone when an attempt is made to call vou. Our working together will best facilitate your needs being addressed in a timely manner.
3. Timing is important. If you or your child is sick, call early in the workday. Likewise, avoid waiting until late in the week to contact us with an acute need.
4. Accurately prescribing medication over the phone is inherently difficult and compromised. If your medical condition has changed significantly since a recent visit or a new condition has emerged we can only provide responsible, effective and ethical medical care by understanding the unique presentation of your symptoms and your experience of your condition. The person-centered health care offered at WellSpring is best delivered in person and we will work to accommodate your needs in a timely manner. Telephone, electronic or other indirect communication can not provide us with the opportunity to serve you as well as seeing you in person.
5. Children and illnesses do not always follow the rhythms of the clinic schedule. Your clinician is available in the beyond clinic hours if you feel that you have a medical condition requiring urgent decision-making and/or treatment; the WellSpring voicemail system (press #2) will contact your clinician and transmit the detailed message you leave. You will be called as soon as possible. In the event of a medical emergency, call 911 or go to the nearest urgent care facility or emergency room.
6. The WellSpring website provides a contact form for communicating with our staff and practitioners. These submissions will be reviewed and responded to but are not a timely or reliable means of communications with your clinician regarding your health care and medical treatment. In general, we at WellSpring prefer to communicate directly on the phone or in person and do not use electronic communications such as email or the WellSpring website for discussing your health care or medical treatment. Such forms of electronic messages are useful and appropriate for matters involving clinic hours and policies, insurance verification, and other matters of general business. The staff email (*care@wellspringofhealth.com*) and WellSpring website contact forms are available to more appropriately serve these functions. The clinicians at WellSpring do not use email for discussing your case or receiving documents. Email and online form submissions do not meet the confidentiality and security standards required by HIPAA and other relevant regulations and thus are not appropriate for transmitting personal information such your birthdate, social security number, passwords, etc.

Thank you!

The Clinicians and Staff of A WellSpring of Natural Health, PC