Christopher Neary ND, LAc
Bend Natural Health
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New Patient Information

Name: ____ Today's date: ____________

Address: ____

City: ________________________________ State: __________ Zip: _________________

Primary phone #: _________________ Email address:______________________________

Age: ______ Sex: ☐ Female ☐ Male Gender if different from sex: _________________

Date of Birth: _______________________

Emergency Contact Information

Name: _______________________________________ Phone: __________________

Insurance Information

Insurance Company: ____________________________________ Phone:________________

Name of Subscriber:_____________________ Relationship to Subscriber:_________________

ID Number: __________________________ Group Number: __________________

Most Recent Primary Care Information

Physician's Name: _____________________ Practitioner Type (MD, etc): _______________

Practice Location: ____________________________ Date of Last Visit: _______________

Are you seeking to establish primary care with Christopher Neary ND, LAc? ☐ Yes ☐ No

Payment Information

Cash/Check ☐ Credit Card ☐ Health Insurance ☐ Workers Compensation ☐ Other ☐

Notice of Patient Privacy Health Insurance Portability and Accountability Act (HIPPA)

We are dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. Required by law: We must have your written consent before we use or disclose to others your Medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect. If you have any questions,

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concerns or complaints about the NOTICE or your medical information, please contact Christopher Neary ND, LAc via phone (541) 980-5625. You may also send a written complaint to the US Department of Health and Human Services.

Holistic and preventative healthcare is enhanced dramatically when the practitioner has a complete picture of the patient physically, mentally, emotionally and spiritually. We ask for your cooperation in completing this questionnaire to the best of your ability. The more information you provide, the better we will be able to serve your health care needs.

Present Health Information

Reason for your visit today: ____________________
____

When did your symptoms appear? ________________

Please list your goals and expectations for treatment
____
____
____
____

Does this condition interfere with:

☐ Work ☐ Daily Routine ☐ Recreation ☐ Sleep

☐ Energy ☐ Digestion ☐ Emotional State

Activities or movements that are difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Is the condition getting: ☐ Worse ☐ Same ☐ Better

How would you best describe your pain:

☐ Sharp ☐ Dull ☐ Throb ☐ Numb ☐ Shooting
☐ Cramp ☐ Ache ☐ Burn ☐ Tingle ☐ Stiff ☐ Swelling
☐ Other ______________________

Please check the number that best rates the severity of your condition: (0 = No Pain, 10 = Worst Pain)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Are you currently receiving treatment for this condition? ☐ Yes ☐ No

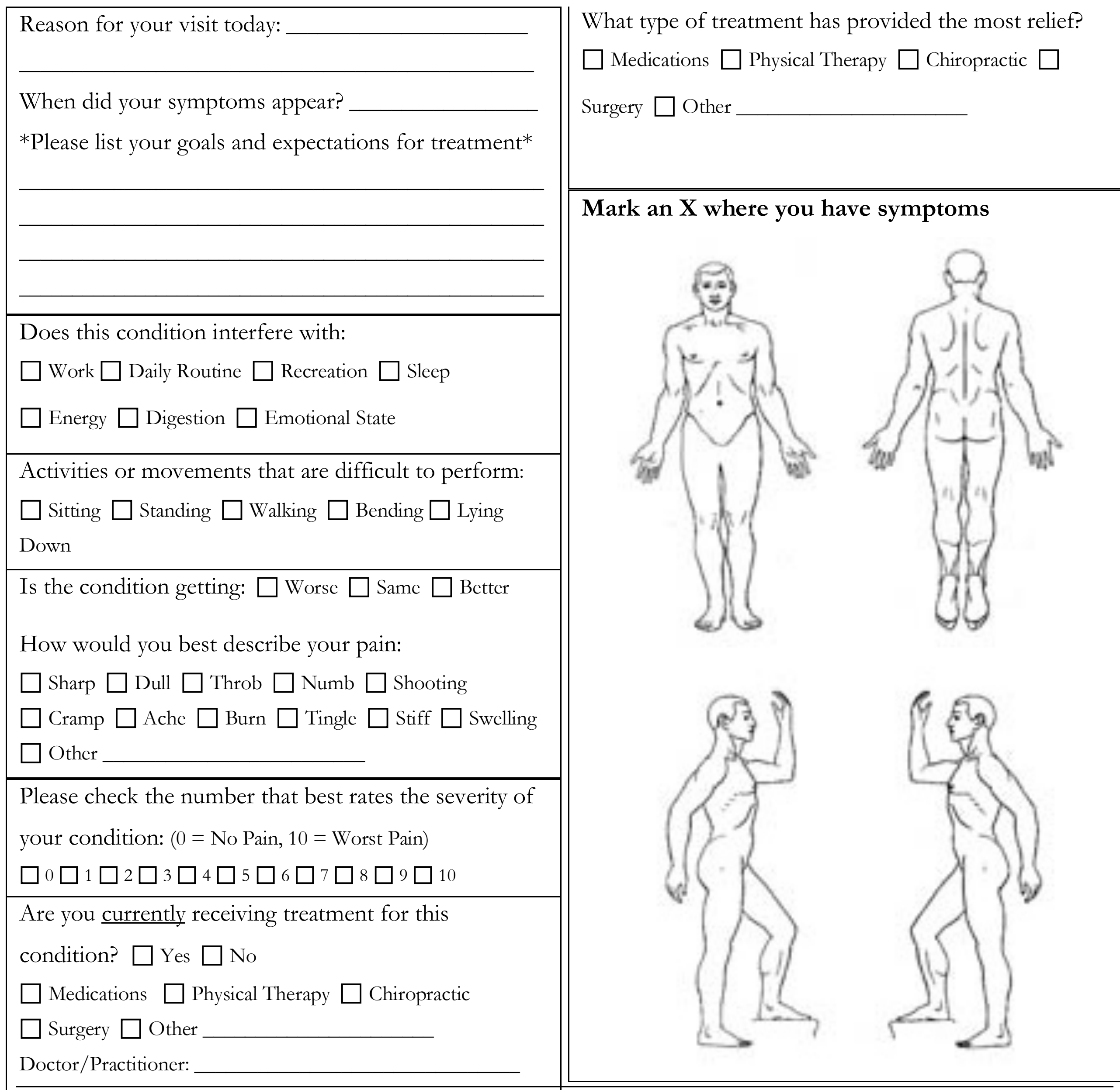
☐ Medications ☐ Physical Therapy ☐ Chiropractic
☐ Surgery ☐ Other ____________________

Doctor/Practitioner: ____________________________

What type of treatment has provided the most relief?

☐ Medications ☐ Physical Therapy ☐ Chiropractic ☐ Surgery ☐ Other ____________________

Mark an X where you have symptoms



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HEALTH HISTORY

Current Medical Issues:

1) ______________________________ When: __________
2) ______________________________ When: __________
3) ______________________________ When: __________

Previous Medical Issues:

1) ______________________________ When: __________
2) ______________________________ When: __________
3) ______________________________ When: __________

Surgical/Hospitalization History:

1) ______________________________ When: __________
2) ______________________________ When: __________
3) ______________________________ When: __________

Blood Work – When was your last blood test? Abnormal results?

1) ____
2) What is your blood type? ______________
3) Any other recent testing? ______________________ When: __________

Date of last physical exam ____________________

What is your level of commitment to address any underlying causes that are impacting your health?

0% ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 100%

How do you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Childhood Illnesses

☐ Rubella (German Measles) ☐ Measles ☐ Mumps ☐ Chickenpox ☐ Roseola
☐ Whooping Cough ☐ Polio ☐ Rheumatic fever ☐ Scarlet Fever ☐ Diptheria
☐ Frequent ear infections or illness as a child ☐ Asthma ☐ Eczema
☐ Difficulties with your mothers pregnancy or birth with you? Explain:________________

Immunizations

☐ Polio ☐ Tetanus ☐ Pertussis ☐ Diptheria ☐ Measles/Mumps/Rubella (MMR) ☐ Other ___

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SOCIAL HISTORY

Relationship: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Occupation: ____________________ Hours per week: ________

Stress Level (1-10): __________ Biggest stressors: ____________________

Exercise x / week: ______________ Type of Exercise: ______________

Exercise Intensity: ☐ Low ☐ Moderate ☐ High

Tobacco: ☐ Never ☐ Previous ☐ Current From: ________ #Years/Years Quit: ________

Alcohol: ☐ No ☐ Yes Drinks/week: __________ Type (wine/Beer, etc)______________

Recreational Drugs
☐ Marijuana Frequency: ☐ Rarely ☐ Some Days ☐ Everyday
☐ Cocaine Frequency: ☐ Rarely ☐ Some Days ☐ Everyday
☐ Methamphetamine Frequency: ☐ Rarely ☐ Some Days ☐ Everyday
☐ Heroin Frequency: ☐ Rarely ☐ Some Days ☐ Everyday
☐ Prescription Drugs
Which:__________ Frequency: ☐ Rarely ☐ Some Days ☐ Everyday

Contagious or sexually/bodily fluid transmitted illnesses
☐ No
☐ Yes Which one(s): ______________________________

FAMILY HEALTH HISTORY

Family Member	**Age(s) (Living or Deceased?)**	**Health Issues**
Father		
Mother		
Siblings (Designate M/F)		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

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Any other relevant family history? ____

____

____

DIET

How much water do you drink per day? ____

What foods do you crave? ____

Are you satisfied with your diet as it is now? _________ If not, why not? ________________

Do you drink Caffeine? _____________ If so, how much and what form? ________________

Typical breakfast:
Typical lunch:
Typical dinner:
Typical snacks:
Beverages, other than water (please include amounts):

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ALLERGIES

Allergies to Medications ____________________

Environmental Allergies ____________________

Seasonal Allergies ____________________

Do you have **severe** reactions to any of the above? ☐ Yes ☐ No

If Yes, Please Describe: ____________________

MEDICATIONS/SUPPLEMENTS

Prescribed/OTC Medication

1) Med __________ Strength __________ How Often __________
2) Med __________ Strength __________ How Often __________
3) Med __________ Strength __________ How Often __________
4) Med __________ Strength __________ How Often __________
5) Med __________ Strength __________ How Often __________
6) Med __________ Strength __________ How Often __________

Supplementation

1) Supp __________ Strength __________ How Often __________
2) Supp __________ Strength __________ How Often __________
3) Supp __________ Strength __________ How Often __________
4) Supp __________ Strength __________ How Often __________

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REVIEW OF SYSTEMS

Please check all that apply. C = current, P = past (1 year). If issue is not relevant, do not check any box.

Conditions
Do you have or have you had any of the following conditions:

C	P	
☐	☐	AIDS/HIV
☐	☐	Alcohol/Drug Dependency
☐	☐	Blood Clots
☐	☐	Bleeding Disorder
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Heart Disease
☐	☐	Hepatitis A/B/C
☐	☐	Herpes
☐	☐	Pacemaker
☐	☐	Stroke
☐	☐	High Blood Pressure

Last Blood Pressure Reading:
__________ / ______________
Date Taken: __________________

C	P	**Generals**
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Chills
☐	☐	Weight loss (past year)
☐	☐	Weight gain (past year)

C	P	**Sleep**
☐	☐	Difficulty falling asleep
☐	☐	Disturbing dreams
☐	☐	Insomnia
☐	☐	Not rested upon waking
☐	☐	Restless sleep
☐	☐	Other _______________

C	P	**Head / Neurologic**
☐	☐	Headaches
☐	☐	Head Injury
☐	☐	Memory Loss
☐	☐	Migraines
☐	☐	Dizziness, Lightheadedness
☐	☐	Numbness/tingling
☐	☐	Muscle weakness

C	P	**Eyes**
☐	☐	Blurry / Impaired vision
☐	☐	Double vision
☐	☐	Eye pain or strain
☐	☐	Redness
☐	☐	Floaters / Spots
☐	☐	Cataracts
☐	☐	Glaucoma

C	P	**Ears**
☐	☐	Ringing in ears/Tinnitus
☐	☐	Pain / Earache
☐	☐	Impaired hearing

C	P	**Nose and Sinus**
☐	☐	Frequent Colds
☐	☐	Hay fever
☐	☐	Sinus Congestion/Infection
☐	☐	Runny nose
☐	☐	Nose bleeds

C	P	**Mouth**
☐	☐	Frequent sore throat
☐	☐	Mouth/teeth pain
☐	☐	Gum issues/Gingivitis
☐	☐	Swollen glands
☐	☐	TMJ / Jaw pain, Grinding
☐	☐	Dry Mouth

C	P	**Throat**
☐	☐	Sore throat
☐	☐	Difficulty swallowing
☐	☐	Halitosis

C	P	**Endocrine**
☐	☐	Excessive Thirst / Hunger
☐	☐	Excessive Sweating
☐	☐	Feeling Hot or Cold
☐	☐	Hyper / Hypo Thyroid
☐	☐	Hypoglycemia
☐	☐	Other: _______________

C	P	**Neck**
☐	☐	Lumps in neck
☐	☐	Goiter
☐	☐	Pain/neck stiffness

C	P	**Cardiovascular**
☐	☐	Chest pain / Tightness
☐	☐	Heart Disease
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Palpitations / Fluttering
☐	☐	Swelling in ankles
☐	☐	Varicose Veins
☐	☐	Other: _______________

C	P	**Respiratory**
☐	☐	Cough
☐	☐	Shortness of breath
☐	☐	Asthma / Wheezing
☐	☐	Difficulty Breathing
☐	☐	Persistent cough
☐	☐	Sputum
☐	☐	Other

C P Gastrointestinal

Frequency of bowel movements:
_________/day or ________/week

C	P	
☐	☐	Abdominal pain
☐	☐	Reflux/Heartburn
☐	☐	Changes in Appetite
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Gas / Bloating
☐	☐	Dark / light colored stools
☐	☐	Undigested food in stool
☐	☐	Ulcers
☐	☐	Liver Disease
☐	☐	Gall Bladder Disease/stone
☐	☐	Blood in stool

C	P	**Urinary**
☐	☐	Pain on urination
☐	☐	Frequency
☐	☐	Urgency
☐	☐	Nighttime Urination:

x/night ____________

C	P	
☐	☐	Blood in urine
☐	☐	Cloudy Urine
☐	☐	Frequent UTI's
☐	☐	Lack of Bladder Control
☐	☐	Kidney Disease / Stones
☐	☐	Other: _______________

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C	P	**Musculoskeletal**
☐	☐	Joint pain/Arthritis
☐	☐	Muscle pain/spasms/cramps
☐	☐	Back pain: Upper/mid/low
☐	☐	Limb Pain: Upper/Lower
☐	☐	Neck pain
☐	☐	Shoulder pain
☐	☐	Stiffness
☐	☐	Other: ________________
☐	☐	Date of last DEXA: ________________

C	P	**Skin, Hair, Nails**
☐	☐	Acne/boils
☐	☐	Itchy skin
☐	☐	Eczema / Hives / Rashes
☐	☐	Dry skin
☐	☐	Color changes
☐	☐	Lumps
☐	☐	Brittle nails
☐	☐	Hair loss
☐	☐	Dry or brittle hair
☐	☐	Other

C	P	**Mental/Emotional**
☐	☐	Anxiety/Nervousness
☐	☐	Depression
☐	☐	Stress/Mental Tension
☐	☐	Mood Swings
☐	☐	Poor Memory
☐	☐	Poor Concentration
☐	☐	Suicidal thoughts
☐	☐	Other _______________

C	P	**Blood**
☐	☐	Cold hands/feet
☐	☐	Easy bleeding or bruising
☐	☐	Cold hands/feet
☐	☐	Varicose veins
☐	☐	Anemia

C	P	**Male Reproductive**
☐	☐	Sexually active

Type of contraception used?
____

Have you had a prostate exam?
☐ Yes ☐ No

Sexual Desire
☐1☐2☐3☐4☐5☐ 6☐7☐ 8☐9☐10

C	P	
☐	☐	Discharge/sores
☐	☐	Testicular pain
☐	☐	Testicular pain / Swelling
☐	☐	Prostate Disease
☐	☐	Impotence
☐	☐	Hernia
☐	☐	Ejaculation concerns
☐	☐	Fertility concerns

C	P	**Female Reproductive**

Age at first menses: _______________
If menopausal, age at last menses:
____

Date of last menstrual period:
____

Length of cycle: ________ days
Duration of menses: ________ days
Quality of blood (dark, bright red, etc)
____

C	P	
☐	☐	Irregular cycles
☐	☐	Painful menses
☐	☐	Heavy menses
☐	☐	PMS
☐	☐	Bleeding between cycles
☐	☐	Clotting
☐	☐	Endometriosis
☐	☐	Ovarian cysts
☐	☐	Vaginal odor
☐	☐	Vaginal discharge
☐	☐	Abnormal PAP
☐	☐	Cervical dysplasia
☐	☐	Breast pain
☐	☐	Breast lumps
☐	☐	Nipple discharge
☐	☐	Menopausal symptoms

Date of last PAP:
____

☐ ☐ Sexually active

Sexual Desire
☐1☐2☐3☐4☐5☐ 6☐7☐ 8☐9☐10

Current form(s) of contraception:
____

Contraception type(s) in the past?
____

Ever used an IUD? What kind?
____

C	P	
☐	☐	Pain during intercourse
☐	☐	Difficulty conceiving

pregnancies: __________
live births: ___________
miscarriages: _________
abortions: ____________