Rainier Valley Natural Medicine
6061 Martin Luther King Jr Way S
Seattle, WA 98118
www.DrSpellen.com

DATE _____

PATIENT PROFILE

First Name:_____
Last Name:_____
Nickname:_____
Birth date: _____ Sex: M/F_____

A note to our patients : Please complete this questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance.

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____
6. _____
   _____

What goals do you have for your visit at the clinic today?

_____
_____
_____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____
3._____ 4. _____
5._____ 6._____

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____
3._____ 4. _____
5._____ 6._____

HEALTH HISTORY:

Please list any severe or life-threatening allergies:

_____

Personal Habits:

Please circle any of the following substances that you use regularly:
Tobacco Coffee/black tea/cola
Alcohol/ Recreational drugs including marijuana
if so list drug_____

Do you follow any particular diet regimens or restrictions? If yes, please describe:_____
_____
_____

Do you exercise regularly? Yes /No
What type?_____
How long?_____
How often? _____

Past History:

Hospitalizations:

_____
_____
_____

Serious Illnesses and Injuries:

_____
_____
_____

Date of last physical/annual exam _____

Date of last blood tests: _____

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PSYCH HISTORY:
Have you ever been touched in a way that made you uncomfortable or was harmful to you without your permission? YES /NO
Have you ever been physically or emotionally abused? YES/ NO
Do you have concerns with abuse or violence in your life now? YES/ NO
How would you describe your overall well being?
_____
_____
_____

PERSONAL AND FAMILY HISTORY:

Please check the "yes" box next to each system that applies to you or one of your family members. Please note what condition in the system applied to family member or you. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	CONDITION		YES	RELATION	CONDITION
Skin				**Urinary**			
Head				**Musculoskeletal**			
Eyes				**Endocrine**			
Ears				**Blood/ Lymphatic**			
Nose				**Allergy/Immune**			
Mouth/Throat				**Neurologic**			
Lungs				**Psychologic**			
Heart/Cardio				**Other**			
Stomach/GI							

SOCIAL HISTORY:

Please circle those that apply: Single/ Married/ Significant other/ Widow
Do you have any children? Yes/ No
Please list their age(s) _____