



Welcome! The information package provided below will help you to prepare for your first visit. Please read and fill out the information requested. It may appear to be a lot of information that I am asking you to bring, however the more information you provide, the easier and quicker it will be for me to formulate a comprehensive treatment plan.

Your first visit will usually be between 1 - 1.5 hours. During this time a comprehensive health assessment is usually done including a physical examination and thorough review of all of your chief complaints. Treatment may begin at this time depending on the complexity of your situation.

Please bring any of the following available to you for your first visit:

- ***all current medications, supplements, vitamins, homeopathics, etc, or comprehensive list of said items.***
- names, doses of any past medications, supplements relevant to your current concerns
- copy of current blood test (last 5 months only), if possible.
- completed forms provided below

Lastly, check the appropriate boxes on the **REVIEW OF SYSTEMS (ROS)** and complete the **Intake Form.**

Ideally, after the first visit I will review your ROS, chief complaints and health history. An individualized treatment plan will then be formulated, which will be discussed with you and implementation will begin on your second visit. This visit can take up to an hour.

I look forward to your first visit and to begin working together to address your health concerns. If you have any questions regarding the procedures described above or otherwise, please feel free to call me.

Sincerely,

Kim Vivian BSc, ND

REVIEW OF SYSTEMS

- Y** A condition you have **NOW**
N A condition you have **NEVER** had
P A condition you have had in the **PAST**

Responses and Comments:

1. GENERAL				
PLEASE USE THE SPACE BELOW TO ELABORATE IF YOU CIRCLED 'Y'. For example, details such as ONSET time, what makes that symptom better or worse, how frequently does it occur, etc.				
Weight				
Weight 1 year ago				
Maximum weight				
When				
Height				
Fatigue/weakness	Y	P	N	
Fever/Chills	Y	P	N	

2. SKIN				
Rashes	Y	P	N	
Eczema, hives	Y	P	N	
Acne, boils	Y	P	N	
Itching	Y	P	N	
Color change	Y	P	N	
Lumps	Y	P	N	
Night sweats	Y	P	N	
Dryness/moistness	Y	P	N	
Temperature	Y	P	N	
Nail changes	Y	P	N	
Change in Mole	Y	P	N	
Skin Cancer	Y	P	N	

3. HEAD				
Headache	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	

4. EYES				
Impaired vision	Y	P	N	
Glasses/Contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing/dryness	Y	P	N	
Double vision	Y	P	N	
Glaucoma	Y	P	N	
Cataracts	Y	P	N	
Blurring	Y	P	N	

Bothered by sun	Y	P	N	
Itching	Y	P	N	
Redness	Y	P	N	
Discharge	Y	P	N	
Blind spot	Y	P	N	

5. EARS

Impaired hearing	Y	P	N	
Earache	Y	P	N	
Dizziness	Y	P	N	
Discharge	Y	P	N	
Infections	Y	P	N	

6. NOSE and SINUSES

Frequent colds	Y	P	N	
Nose bleeds	Y	P	N	
Stuffiness	Y	P	N	
Hay fever	Y	P	N	
Sinus problems	Y	P	N	

7. MOUTH and THROAT

Frequent sore throat	Y	P	N	
Sore tongue/mouth	Y	P	N	
Gum problems	Y	P	N	
Hoarseness	Y	P	N	
Dental cavities	Y	P	N	
Loss of taste	Y	P	N	

8. NECK

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

9. RESPIRATORY

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	

(SOB)				
SOB at night	Y	P	N	
SOB lying down	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin Test	Y	P	N	
Last Chest -ray				

10. CARDIOVASCULAR				
Heart disease	Y	P	N	
Angina	Y	P	N	
High blood pressure	Y	P	N	
Murmurs	Y	P	N	
Rheumatic fever	Y	P	N	
Chest pain	Y	P	N	
Swelling in ankles	Y	P	N	
Rapid heart beat	Y	P	N	
Cyanosis (bluish color to lips or nails)	Y	P	N	
Past ECG	Y	P	N	
Other heart tests				

11. BREASTS				
Do you do self exams?	Y	P	N	
Lumps	Y	P	N	
Pain (or tenderness)	Y	P	N	
Nipple discharge	Y	P	N	

12. 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 – number pre day?				
Is this a change?	Y		N	
Blood in stool	Y	P	N	
Belching or passing gas	Y	P	N	
Jaundice (yellow skin)	Y	P	N	
Liver disease	Y	P	N	
Gall Bladder disease	Y	P	N	
Ulcer	Y	P	N	

Indigestion	Y	P	N	
Diarrhea	Y	P	N	
Rectal bleeding	Y	P	N	
Hemorrhoids	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	
Hernias	Y	P	N	

13. URINARY

Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequency at night	Y	P	N	
Unable to hold urine	Y	P	N	
Frequent infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency	Y	P	N	
Hesitancy	Y	P	N	

14. MALE REPRODUCTIVE

Hernias	Y	P	N	
Testicular masses	Y	P	N	
Testicular pain	Y	P	N	
Sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal disease	Y	P	N	
Discharge or sores	Y	P	N	
Other relevant information about your fertility or sexual life you feel relevant? Please use space on right side.				

15. FEMALE REPRODUCTIVE

Age menses began				
Average number of days				
Length of cycle				
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Pain during intercourse	Y	P	N	
Painful menses	Y	P	N	
Excessive flow	Y	P	N	
PMS	Y	P	N	
Birth control?	Y	P	N	
What type?				
Number of pregnancies				
Number of live births				

Number of miscarriages				
Number of abortions				
Difficulty conceiving	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal Disease	Y	P	N	
Other relevant information about your fertility or sexual life you feel relevant? Please use space on right side.				
Last menstrual period				
Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Last PAP - (date)				

16. MUSCULOSKELETAL				
Joint pain or stiffness	Y	P	N	
Arthritis	Y	P	N	
Broken bones	Y	P	N	
Muscle spasms or cramps	Y	P	N	
Weakness	Y	P	N	
Joint swelling	Y	P	N	
Backache	Y	P	N	

17. PERIPHERAL VASCULAR				
Deep leg pain	Y	P	N	
Cold hands/feet	Y	P	N	
Varicose veins	Y	P	N	
Thrombophlebitis	Y	P	N	
Leg cramps	Y	P	N	
Extremity numbness	Y	P	N	
Extremity coldness	Y	P	N	
Extremity swelling	Y	P	N	
Extremity ulcers	Y	P	N	

18. NEUROLOGIC				
Fainting	Y	P	N	
Seizures/Convulsions	Y	P	N	
Paralysis	Y	P	N	
Muscle weakness	Y	P	N	
Numbness or tingling	Y	P	N	
Loss of memory	Y	P	N	
Involuntary movement	Y	P	N	
Loss of balance	Y	P	N	
Speech problems	Y	P	N	

19. ENDOCRINE				
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Heat or cold intolerance	Y	P	N	
Thyroid trouble	Y	P	N	
Excessive thirst	Y	P	N	
Excessive hunger	Y	P	N	
Excessive urination	Y	P	N	
Excessive sweating	Y	P	N	
Diabetes	Y	P	N	
Hypoglycemia	Y	P	N	
Hormone therapy	Y	P	N	

20. BLOOD/LYMPHATIC

Anemia	Y	P	N	
Easy bleeding or bruising	Y	P	N	
Past transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

20. ALLERGIC HISTORY

Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Allergies? Please list				

21. EMOTIONAL

Depression	Y	P	N	
Mood swings	Y	P	N	
Anxiety or nervousness	Y	P	N	
Tension	Y	P	N	
Phobias	Y	P	N	
Alcohol/Drug abuse	Y	P	N	
Insomnia	Y	P	N	

22. HOBBIES/HABITS

Please answer yes (Y) or no (N)				
Do you eat three meals daily?	Y	N	What are your main interests and hobbies?	
Do you awake rested?	Y	N		
Do you sleep well?	Y	N		
Do you average 6-8 hours sleep?	Y	N		
Do you enjoy your work?	Y	N		
Do you watch television?	Y	N		
How many hours/day?				
Do you read?	Y	N	Do you exercise?	Y N
How many hours/day?				
What forms?				
Do you take vacations?	Y	N		
Have you been treated for drug	Y	N		

dependence?			
Do you use recreational drugs?	Y	N	
Do you use alcoholic beverages?	Y	N	
Have you been treated for alcoholism?	Y	N	How often?