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Name _____ Date _____
Age _____ Date of birth _____ Sex: Male Female
Address _____ City _____ State ____ Zip _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Email _____
Emergency Contact _____ Relationship _____
Telephone (Home) _____ (Work) _____ (Cell) _____

How did you hear about Thrive? _____

HEALTH / WEIGHT HISTORY

When, where and by whom did you last receive medical care? _____

What are your primary health concerns?

Weight: _____ lbs. Weight one year ago: _____ lbs.
Minimum weight as an adult: _____ lbs. At what age? _____
Maximum weight as an adult: _____ lbs. At what age? _____
Height? _____

Have you been on a diet before? Yes / No
If yes, please specify which diet(s) and why you think they didn't work for you:

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

What hospitalizations or surgeries have you had? When did they occur?

When was your last blood test? _____ What type of test? _____
What is your blood type? _____
Any other tests recently? _____

List all drugs, vitamins, herbs being taken at present with dosage:

Are you allergic to any medications or supplements? Y N
If yes, please list

FAMILY HISTORY

Please list ages, any major health problems, and if deceased, what they died from and at what age.

Mother _____

Father _____

Your Siblings _____

Mother's Side:

Grandfather _____

Grandmother _____

Father's Side:

Grandfather _____

Grandmother _____

SOCIAL HISTORY

Occupation _____ Work hours _____

Are you: Married ___ Separated ___ Divorced ___ Single ___ Widowed ___ Partner ___

With whom do live: Spouse ___ Parents ___ Relatives ___ Friends ___ Alone ___ Other ___

Do you have the support of family and friends to make positive changes in your life? _____

Military Status: When did you serve? _____ Where? _____

Do In what areas of your life do you experience stress? Work Family Life Social Life Financial

HEALTH HABITS

Do you drink alcohol? ___ If so, what: Wine ___ Beer ___ Other alcohol _____

Do you use tobacco or have you in the past? ___ If so, how much? _____

Total number of years smoking? ___ Total number of years since stopped smoking? _____

Do you now or have in the past used marijuana or other drugs? ___ If yes, which drugs, how often and for how long?

List any longterm health problems that have resulted from taking these drugs

How is your energy level? What are your best times and worst times?

Do you exercise? _____

Do you feel good after exercise? _____

How often? (Hours/day and days/week) _____

What type of exercise? _____

Do you make time for rest, relaxation during the day and/or before bed? ___ How often? _____

How do you relax? _____

What are your primary interests or hobbies? _____

DIET

Where do you usually buy your food? _____ Who cooks the food you eat? _____

List the primary foods included in your diet. _____

List the foods excluded from your diet. _____

List any of the following (and relative amounts) eaten regularly by you: Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods or foods you suspect may be harmful to your health:

List any of the foods you crave, regardless of their nutritional value (including sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.):

Are you satisfied with your diet as it is now? ____ If not, why not? _____

Any food allergies? _____

Number of meals eaten per day: 1 2 3 more than 3

Do you eat breakfast? Yes / No

When are you most hungry? _____

How do you feel your appetite compares with others? _____

How long is it typically between meals & snacks? _____

What do you drink? _____

How often do you drink? _____

Do you feel thirsty? _____

Do you use caffeine and/or artificial sweeteners? _____

Do you notice mood changes before and/or after mealtimes? _____

Do you eat in response to certain feelings – boredom, anxiety, depression, guilt, stress, joy or some other emotion? Please specify.

Do you feel addicted to food? _____

Do you feel guilt after eating? _____

Do you eat when you're not physically hungry? _____

Do you eat to the point of physical discomfort? _____

Have you ever starved yourself to lose weight?

Have you ever purged (vomiting, laxative use, excessive exercise) after eating?

Have you ever considered purging? _____

SLEEP

Do you have trouble falling asleep? ____ If yes, what keeps you up? _____

Do you sleep straight through the night? ____ If not, what time do you usually wake? _____

Average number of hours you sleep _____ Do you wake refreshed? ____

Do you have recurring dreams or nightmares? ____ If yes, what is the theme? _____

What position do you usually sleep in? _____

Is there a position you cannot sleep in? ____ If yes, which one? _____

How many pillows do you sleep on? ____ Nights sweats? _____

ENVIRONMENTAL EXPOSURES

Please circle any of the following you feel bothered by:

Sunshine Lack of sunshine Dampness Dryness Cold Heat Dust/Mold Cat/Dog hair
Car fumes Poor air/ventilation Fluorescent lighting Chemicals Perfumes

FEMALE REPRODUCTIVE HEALTH

Have you ever used birth control pills? ____ For how long? _____ What kind? _____

Hormone replacement therapy? _____ For how long? _____ What kind? _____

Age when menstrual periods began _____ Did you have a normal puberty? _____

Period every _____ days. Regular: Yes / No Periods usually last _____ days (average)

Quality of blood? (i.e. dark red, bright red, clots) _____

Amount of flow (i.e. # of pads or tampons/day) _____

Pain or cramping? _____ PMS? _____

Do you currently, or have had in the past, problems with infertility _____ if yes, explain _____

Number of: pregnancies _____ births _____ miscarriages _____ abortions _____

Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (please circle one, 0 = none)

Have you had any of the following concerning your breasts: Pain Lumps Infection Nipple discharge

MALE REPRODUCTIVE HEALTH

Have you had any of the following: ED Testicular pain Prostate problems Hernia

Have you had a prostate exam? _____ If so, when? _____

Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (please circle one, 0 = none)

MEDICAL HISTORY

Please circle:

O = occasionally Y = condition you have now N = never had this problem P = condition you have had in the past

ENERGY

Fatigue O Y N P

SKIN

Rashes O Y N P

Eczema, hives O Y N P

Itching O Y N P

Color change O Y N P

Lumps O Y N P

HEAD

Head aches O Y N P

P

Head injury Y N

P

EYES

Impaired vision O Y N P

Eye pain O Y N P

Tearing/dryness O Y N P

Double vision O Y N P

Glaucoma O Y N P

Cataracts Y N P

EARS

Impaired hearing O Y N P

P

ringing O Y N P

Earache O Y N P

NOSE and SINUSES

Frequent colds O Y N P

Nose bleeds O Y N P

Stiffness O Y N P

Hay fever O Y N P

Sinus problems O Y N P

MOUTH and THROAT

Frequent sore throat O Y N P

Sore Tongue O Y N P

Gum problems O Y N P

Hoarseness O Y N

P

Dental cavities O Y N P
Last dental exam? _____

IMMUNE

History of cancer Y N

If yes, what type? _____

RESPIRATORY

Cough O Y N P

Sputum O Y N P

Spitting up blood O Y N

P

Wheezing O Y N P

Asthma O Y N P

Bronchitis O Y N P

Weeping O Y N P

Compulsions O Y N P

Excessive anger O Y N

P

Restless, bored O Y N P

Pneumonia O Y N

P

Pleurisy O Y N P

Emphysema Y N

Trouble breathing O Y N P

Pain on breathing O Y N

P

Short of breath O Y N P

At night O Y N P

Lying down O Y N

P

Tuberculosis Y N P

CARDIOVASCULAR

Heart disease Y N

Angina O Y N P

Hypertension O Y N P

Murmurs O Y N P

Rheumatic fever O Y N

P

Chest pain O Y N P

Swelling in ankles O Y N

P

Palpitations O Y N

P

URINARY

Pain on urination O Y N

P

Increased frequency O Y N P

Frequency at night O Y N P

Unable to hold urine O Y N P

Frequent infections O Y N P

Kidney stones O Y N P

Kidney disease Y N P

EXTREMITIES

Deep leg pain O Y N P

Cold hands/feet O Y N P

Varicose veins O Y N P

Thrombophlebitis O Y N

P

Nail Fungus O Y N

P

Restless legs O Y N P

EMOTIONAL

Anxiety, panic O Y N P

Depressed, hopeless O Y N P

Mood swings O Y N P

Weeping O Y N P

Compulsions O Y N P

Excessive anger O Y N

P

Restless, bored O Y N P

GASTROINTESTINAL

Belching/gas O Y N P

Gall bladder	O	Y	N	P
Heartburn	O	Y	N	P
Indigestion		O	Y	N
P				
Liver problems	O	Y	N	P
Jaundice	O	Y	N	P
Vomiting	O	Y	N	P
Vomiting blood	O	Y	N	P
Blood in stool	O	Y	N	P
Abdominal cramps	O	Y	N	P
Hemorrhoids	O	Y	N	P
Constipation	O	Y	N	P
Diarrhea	O	Y	N	P

MUSCULOSKELETAL

Joint pain, stiffness	O	Y	N	P
Arthritis	O	Y	N	P
Broken bones	O	Y	N	P
Muscle spasms	O	Y	N	P
Weakness	O	Y	N	P

NECK

Lumps	O	Y	N	P
Swollen glands	O	Y	N	P
Goiter	O	Y	N	P

BLOOD

Easy bruising	O	Y	N	P
Anemia	O	Y	N	P

ENDOCRINE

Hypothyroid	O	Y	N	P
Hyperthyroid	O	Y	N	P
Low blood sugar		O	Y	N
P				
Diabetes		Y	N	
If yes, what type?	_____			

NEUROLOGICAL

Fainting	O	Y	N	P
Seizures	O	Y	N	P
Paralysis	O	Y	N	P
Numbness/tingling	O	Y	N	P
Memory loss	O	Y	N	P

WHEEL OF LIFE

Vitality and health are a balance of many factors. Using the pie graph below please shade your level of satisfaction in each area as it relates to you . For example: if you are extremely happy in your job, shade the entire pie shape for “Career.” Do the same for each area, starting from the center point radiating outwards.

