Natural Medicine of Denver
Rachelle Forsberg, ND, LAc

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

Gender:_____ Occupation: _____

Reason for visit (Focus on your most concerning illness. Please include the location, when it started, how often, what the sensation feels like, what treatments you've tried, anything that makes it better or worse, and any other symptoms that happen at the same time):

_____

_____

Current medications: _____

_____

Current supplements/vitamins/herbals: _____

_____

Current therapies: _____

_____

Allergies: _____

Any surgeries or hospitalizations and dates: _____

_____

Past FAMILY medical history:

___ Alcoholism ___ Arthritis ___ Asthma ___ Blood Disorder ___ Cancer ___ Dental Amalgams

___ Diabetes ___ Depression ___ Emphysema ___ Glaucoma ___ Heart Disease ___ High Blood Pressure

___ Kidney Disease ___ Thyroid Disease ___ Toxic Exposures ___ Tuberculosis ___ Other

If other, please list: _____

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Are any of your family members deceased? Cause of death? _____

_____

PERSONAL medical history:

___ Alcoholism ___ Arthritis ___ Asthma ___ Blood Disorder ___ Cancer ___ Dental Amalgams

___ Diabetes ___ Depression ___ Emphysema ___ Glaucoma ___ Heart Disease ___ High Blood Pressure

___ Kidney Disease ___ Thyroid Disease ___ Toxic Exposures ___ Tuberculosis ___ Other

If other, please list: _____

Date of last colonoscopy? Any abnormal results? _____

Date of last bone density scan? Any abnormal results? _____

Date of last fasting blood sugar? Any abnormal results? _____

Date of last prostate screening? Any abnormal results? _____

What are your goals for this visit? _____

What are your long-term health goals? _____

What brings you joy in life? _____

What are your current healthy habits? _____

Are your currently seeing any healthcare professionals? What are their names and where are they located?

_____

_____

Have you, in the past or currently, experienced: ____ Sexual abuse ____ Physical abuse ____ Emotional abuse

Are you currently: ____ Single ____ Married ____ Divorced ____ Widower

Have you been married more than once? ____ Yes ____ No If yes, how many times: _____

Do you have any children? How many? Gender and age? _____

_____

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Are you sexually active? ____ Yes ____ No

Do you currently have more than one sexual partner? ____ Yes ____ No

Past and Current form of birth control / STD prevention: _____

_____

Any history of a sexually transmitted disease? _____

Do you smoke cigarettes? ____ Yes ____ No If yes, how many packs per day? If quit, when? _____

Do you drink alcohol? ____ Never ____ Occasionally ____ Moderately ____ Heavily ____ Quit

Do you take any recreational drugs? Type? Frequency? _____

_____

Do you drink coffee? ____ Yes ____ No If yes, how much per day? _____

Do you drink soda? ____ Yes ____ No If yes, how frequently? _____

Do you drink water? ____ No ____ Filtered ____ Bottled ____ Tap ____ Spring

How often do you exercise? What type of exercise? _____

_____

Sleep quality: ____ Restful ____ Wake up feeling refreshed ____ Nap Hours per night? _____

FEMALES:

Date of your last period: _____ Are your periods at regular intervals? Days in cycle? _____

Number of pregnancies, births, miscarriages, abortions, or living children? _____

_____

Date of last PAP smear? Any history of abnormal PAPs? When? _____

_____

Date of last mammogram? Any history of an abnormal mammogram? When? _____

_____

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Review of Systems:

Constitutional Symptoms			Gastrointestinal			Genitourinary		
Fatigue	Y	N	Abdominal Pain	Y	N	Urine Retention	Y	N
Chills	Y	N	Nausea/Vomiting	Y	N	Painful Urination	Y	N
Headache	Y	N	Indigestion/Heartburn	Y	N	Urinary Frequency	Y	N
Fever	Y	N	Diarrhea	Y	N	Nighttime Urination	Y	N
Other	Y	N	Constipation	Y	N	Other	Y	N
Eyes			Other	Y	N	Respiratory		
Blurred Vision	Y	N	Cardiovascular			Wheezing	Y	N
Double Vision	Y	N	Chest Pain	Y	N	Frequent Cough	Y	N
Pain	Y	N	Varicose Veins	Y	N	Shortness of Breath	Y	N
Other	Y	N	High Blood Pressure	Y	N	Other	Y	N
Allergic/Immunologic			Other	Y	N	Hematologic/Lymphatic		
Hay Fever	Y	N	Integumentary			Swollen Glands	Y	N
Drug Allergies	Y	N	Skin Rash	Y	N	Blood Clotting Disorder	Y	N
Other	Y	N	Boils	Y	N	Other	Y	N
Neurological			Persistent Itch	Y	N	Psychologic		
Tremors	Y	N	Other	Y	N	Are you generally satisfied		
Dizzy Spells	Y	N	Musculoskeletal			with your life?	Y	N
Numbness/Tingling	Y	N	Joint Pain	Y	N	Do you feel severely		
Other	Y	N	Neck Pain	Y	N	depressed?	Y	N
Endocrine			Back Pain	Y	N	Have you considered		
Excessive Thirst	Y	N	Other	Y	N	suicide?	Y	N
Too Hot	Y	N	Ear/Nose/Throat/Mouth					
Too Cold	Y	N	Ear Infection	Y	N	**OFFICE USE ONLY** # of Answers	Level of Service	
Tired or Sluggish	Y	N	Sore Throat	Y	N	0 - 1	1 or 2	
Other	Y	N	Sinus Congestion	Y	N	2 - 9	3	
			Other	Y	N	10+	4 or 5	

Any other issues you would like to discuss?

_____

_____

_____