

PERSONAL HISTORY INTAKE INFORMATION

Today's Date: 11-12-2019

First Name: Rose Last Name: Kuhlman Birth Date: 9/25/53 Age: 66

Marital Status: married Level of Education: 12 grade

Occupation: retired Retired? Yes No

↳ ATM service for husband's company

Your Primary Care Provider:

Name: Dr. Thomas Dawson (Evergreen HealthCare) Phone: 425-485-6561

Date of Last Physical: 2 yrs

Active Medical Problems:

High Blood pressure

Husband - heart attack

No osteoporosis

10 years ago

Urinary incontinence

Hypothyroid

Prescription & over the counter medications you are currently taking (include doses):

Oxycodone 5mg/325 3X/day

Lisinopril 20mg 1X day

Diclofenac 75mg 2X/day

Methocarbamol as needed

Allergies – Drugs:

Sulfa

Allergies – Foods & Other:

Nutrients/Supplements you are currently taking & current amount:

B-12 5000 mcg ~ 7500 mcg

D 3,000 units -

Multi Vit

PATIENT GOAL SHEET

Please pick your top 10 goals for which areas you would like to work on. Rank them with 1 being the highest priority and 10 being the lowest priority using each number only once.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Lose Weight
<small>(Syndrome X) Decomposition</small> | <input checked="" type="checkbox"/> Lower Dementia Risk |
| <input type="checkbox"/> Increase Strength/Muscle | <input type="checkbox"/> Lower Cancer Risk |
| <input type="checkbox"/> Improve Libido/Sexual Function | <input type="checkbox"/> Improve Sleep |
| <input type="checkbox"/> Lower Diabetic Risk | <input checked="" type="checkbox"/> Decrease Pain |
| <input type="checkbox"/> Improve Diabetes Control | <input checked="" type="checkbox"/> Balance Hormones |
| <input checked="" type="checkbox"/> Lower Blood Pressure | <input checked="" type="checkbox"/> Increase Energy |
| <input checked="" type="checkbox"/> Improve Cholesterol Levels | <input type="checkbox"/> Increase Stamina |
| <input type="checkbox"/> Treat Menopausal Symptoms | <input checked="" type="checkbox"/> Improve Memory |
| <input type="checkbox"/> Improve Mental Function | <input checked="" type="checkbox"/> Increase Bone Density
<small>(3 yrs)</small> |
| <input checked="" type="checkbox"/> Improve Fatigue | <input type="checkbox"/> Improve Skin Appearance |

Other areas of your health you would like to improve:

Patient Name: Rose Kuhlman

HOSPITALIZATIONS Please include surgeries, illnesses, severe accidents, births, and miscarriages.

Year	Procedure	Reason	Outcome
1977	tubaligation		No Kids
1968	tonsillectomy	Sore throats	Fine
2012	cyst removal	ovary	Fine
2005	uterus removal		

MEDICAL CONDITIONS Check any conditions you have had in the past.

- ADD/ADHD
 AIDS/HIV
 Allergies/Asthma
 Anemia
 Alcohol/drug problem
 Anorexia/Bulimia
 Arthritis: Type: Osteo
 Atrial Fibrillation
 Bipolar Disorder
 Bleeding Disorder
 Back pain
 Cancer: Please specify:

 Candida / Yeast
 Chronic Fatigue
 Colitis: Type:

 Coronary Artery Disease
 Crohn's Disease
 Depression
 Dermatomyositis
 Diabetes – Type I
- Diabetes – Type II
 Emphysema
 Epilepsy/Seizure
 Fibromyalgia Goiter
 Heart Disease: Type: _____
 Hepatitis A, B, or C
 High cholesterol
 Hiatal Hernia/Reflux
 Hypertension / High BP
 Gout
 Irritable Bowel
 Jaundice
 Kidney Disorder
 Kidney Stones
 Liver Disease
 Lupus
 Migraines
 Multiple Sclerosis
 Myocardial Infarction, past or asymptomatic
 Myocardial Infarction symptomatic
 Obsessive Compulsive Disorder
- Obstructive Sleep Apnea
 Osteoporosis
 Pancreatitis
 Panic Disorder
 Parkinson's
 Pneumonia
 Polio
 Psoriasis
 Rheumatic Fever
 Rheumatoid Arthritis
 Pelvic Infl Disease
 Sinusitis
 Sjogrens
 Stroke / TIA
 Thyroid problem
 Root canal
 TMJ
 Ulcers
 Urinary Infection
 Psychiatric hospitalization
 Other:

cluster headaches

FAMILY HISTORY Please complete health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father			58	Heart?
Mother	87	Dementia		
Brother(s)			58	Diabetes Kidney fail
	104	Heart		
Sister(s)	70	Cancer	70	Cancer
	44	Cancer		

Disease	Relation
Arthritis/Gout	Mom
Asthma/Hay Fever	
Cancer (type):	Aunt, Breast Sisters colon uterine
Drugs/Alcohol	
Diabetes	Grandmother
Heart Disease	Dad Brothers
High Blood Pressure	Me
Osteoporosis	Mom
Stroke	

RECENT TESTS

Have you had any of these tests in the past 5 years?

Test	Date	Reason	Result
Chest X-Ray			
EKG			
EGD (Stomach)			
Colonoscopy			
Ultrasound	2017	Knees	Osteoarthritis → 1-2 weeks ago full noise in knee joints
CT Scan	Back	2018 Car accident	Back - symptoms many months ago Knee - normal
MRI			
Bone Density (DEXA)			
Other	X-Rays	2015 Knees	

HEALTH HABITS

Which substances do you consume?

Substance	How Much?	
Caffeine	coffee	Mostly Decaf / cups, cans/day / Caffeine / I usually
Cigarettes	Used to	packs/day /
Are you interested in quitting? Or have you quit? Y / N		When did you quit? 2004
Alcohol	NO	Type Amount
Drugs	NO	Type Amount
Chew Tobacco	NO	Amount
Nutrasweet	NO	Servings per day:
Saccharin	NO	Servings per day:
Splenda	NO	Servings per day:
MSG		Servings per day:

FEMALE HORMONE REVIEW

Have you ever had any of these symptoms? Review this list of symptoms and check the ones that apply.

- Acne - over my face
- Bloating late in cycle
- Cravings for sugar, chocolate
- Cramps/clots with periods
- Endometriosis
- Facial hair *done in white*
- Fibro-cystic Breasts *pink hair chin*
- Hot flashes
- Irregular periods
- Increased fat around hips/thighs
- Lack of periods
- Leak Urine
- Loss of interest in sex
- Migraines late in cycle
- Mood swings *more*
- Ovarian Cysts
- Painful periods
- Painful sex
- PMS (____ days)
- Polycystic Ovaries
- Problems with Infertility
- Spotting after menopause
- Unusual vaginal discharge
- Uterine Fibroid
- Vaginal Dryness/Pain
- Vaginal irritation

Date of 1st day of last period _____ Birth control method: _____ Are you pregnant? Yes/No

Date of last Pap test _____ Normal/Abnormal

Date of last Mammogram _____ Normal/Abnormal

Date of Menopause _____ Have you ever had an abnormal pap? Yes/No When? _____

What hormones have you used in the past? _____ *NH*

Any problems with these hormones? _____

MALE HORMONE REVIEW

Date of last prostate exam: _____ Normal / Abnormal

Review this list of symptoms and check any that apply.

- Bladder not emptying completely
- Can't maintain erection
- Crooked/curved erection
- Difficulty in initiating stream
- Enlarged prostate
- Erections less firm
- Lower sex interest
- Night-time urination frequency ____ /night
- Premature ejaculation
- Slowing urinary stream

DIET Please check the most appropriate answer:

1. I consume meals prepared from scratch.

Less than 10% of time 10% of time 25% of time 50% of time 75% or greater
2. I eat at restaurants.

Less than 10% of time 10% of time 25% of time 50% of time 75% or greater
3. I eat fast foods.

Less than 10% of time 10% of time 25% of time 50% of time 75% or greater
4. I tend to crave/eat the following foods:

Sugar Whole Grain Fruit Juice Alcohol overeat nuts Chocolate Fatty Food/Oil Bread/Pasta
5. I usually crave at the following times:

After meals Through morning Through afternoon Evenings No specific time
6. I tend to overeat:

Never Seldom Often
7. I drink 10 oz of water per day.

Tap Well Bottled Distilled Filtered

WEIGHT LOSS

1. How concerned are you about your weight? (Circle, 1 = not at all, 10 = very much)

1 2 3 4 5 6 7 8 9 10
2. How much help do you need with your weight loss? (Circle, 1 = none, 10 = much)

1 2 3 4 5 6 7 8 9 10
3. How long has your weight been a problem?

< 5 years > 5 years Lifetime Since menopause Since pregnancy Stressful event
4. Where do you tend to carry most of your weight?

Hips and thighs Belly Face All over
5. As an adult my lowest weight has been/is: 118 Date: 1972
6. As an adult my highest weight has been/is: 165 Date: 2017
7. What type of weight loss plan worked best for you in the past?
8. Your current weight: 244 Goal weight: 144

STRESS

1. Rate your overall current stress level:

Extreme High Medium Low

2. Evaluate each type of stress:

Types of Stress	Rating				Duration of Stress			Resolution Within			
	Extreme	High	Med	Low	Weeks	Months	Years	1yr	5yrs	10yrs	Never
Family/Relatives			X								
Home			X								
Financial				X							
Work											
Relationship with:											
Illness											
Illness Involving:											
Transition in: Life/ Home/Relationship/ Work											
Loss of Loved One/ Work			X								

3. Check Yes or No:

Yes No

Do you feel like your life is too busy?	Sometimes
Do you feel burdened with life?	Sometimes
Do you suffer from melancholy?	X
Do you have a low sexual interest?	X
Do you have a bleak attitude about life?	X
Are you angry or frustrated with certain aspects of life?	Pain
Is it hard for you to enjoy life in general?	Sometimes
Do you envy other people who seem happier in general?	X
Are you easily distracted?	X
Are you impulsive?	X
Are you plagued with unfinished projects?	X
Do you lose things or frequently misplace things?	Sometimes

SLEEP

- How much sleep do you get at night (on average)? 4-5 Hours
- My usual bed time is: 11-12 am/pm
- My usual wake time is: 5-6 am/pm
- Approximate time before falling asleep is: 5 minutes
- Do you awake in the night? Yes How many times? 2 to 3 Why? UNKNOWN

Rough last
night last 3 days
no 2 weeks ago

6. Check yes or no:

Yes

No

I usually need an alarm to wake up.		X
My sleep is not restful.	SOMETIMES	X
I have difficulty falling asleep.		X
I wake at night feeling like I am choking, being smothered or kicking my legs.		X
My partner notices I snore heavily.		X
My partner notices I stop breathing through the night along with my snoring.		
I have restless legs that disturb my evening or sleep.		X
I wake at night and it is difficult to go back to sleep.	X	X
I wake at night hungry or thinking of food.		X
I have daytime drowsiness or sleepiness.	X	
If I am not active during the day I tend to fall asleep. (meetings, driving, etc.)	SOMETIMES	
I am a night shift worker.		X
I have or might have sleep apnea.	X	

EXERCISE

Complete ONLY if you are currently exercising.

10 yrs - None Now - Rehab knows/bad

1. Exercise (s) you participate in:

- Aerobic Weights Walking Swimming Bicycling Running
 Other: _____

2. How often do you exercise?

- Once/wk Twice/wk Three times/wk Four times/wk Five or more times/wk

3. What is the average duration of exercise you get at one time? _____ minutes

4. What motivates you to exercise? _____

5. Are you experiencing difficulty with your exercise routine? Yes/No

6. If yes, please explain: _____

Please complete if you are NOT currently exercising.

1. What prevents you from exercising?

- Time Interest Energy Injury Motivation

2. Do you experience pain with exercising? Yes/No

3. If you have pain, where is it located? _____

4. How do you prefer to work out?

- Gym With a partner With a trainer Alone

MOTIVATION

Please reflect on the following statements and circle the most appropriate.

On a scale of 1 – 5, 1 = do not agree and 5 = strongly agree

I am prepared to make changes in my life.

1 2 3 4

5
5

It is important to make the changes now, not later.

1 2 3 4

5
5

I will find the time to exercise regularly.

1 2 3 4

5
5

I am willing to eat differently.

1 2 3 4

5
5

I am willing to take my supplements as my doctor prescribes.

1 2 3 4

5
5

I will take my medications as my doctor prescribes.

1 2 3 4

5
5

I will work with my doctor to find the right regimen for me.

1 2 3 4

5
5

I will not expect instant results and perfect outcomes.

1 2 3 4

5
5

I recognize that this is a long-term process, not a quick fix.

1 2 3 4

5
5

Do you currently have any of the following symptoms?

Adrenal

Yes No

Fainting/collapse	X
Palpitations	X
Salt craving	X
Muscle tension	X
Easily frustrated	X
Sweat easily – palms/armpits	X
Sugar craving	X
Panic attacks	X
Feeling overwhelmed	X
Excessive hunger	X
Prone to infection/sickly	X
Low blood pressure	X
Light headed when standing up	X
Racing mind, prevent sleep	
Sluggish in morning – slow start	X
Need sunglasses in bright light	X
Low back pain – worse w/ fatigue or stress	X

Cardiovascular/Respiratory

Yes No

Chest pain	X
Blood in sputum	X
Unusual cough	X
Shortness of breath	(SOMETIMES)
Swollen Ankles	X
Rapid heart beat	X
Leg pain with walking	X
Snoring excessively	X
Fainting/collapse	X

Metabolic, T3, or Adrenal

Yes No

Migraines	X
Constipation	X
Fluid Retention	X
Crave caffeine	X
Dry coarse skin	X
Deepening voice	X
Dry or thinning hair	X
Cold hands and feet	X
Elevated cholesterol	X
Low body temperature	X
Fatigue/exhausted by day's end	X
Brittle unhealthy nails	X
Fibromyalgia	X
Chronic fatigue	X

Metabolic or T4

Yes No

Decreased Memory	X
Depression	X
Anxiety	X
Can't multi-task as well	X
Low ambition/motivation	X
Decreased concentration	X
Foggy/spacey/muddled mind	X
Hard to follow a train of thought	X

Gastro-intestinal

Yes No

Fluid retention, puffy extremities	X	
Bright blood in stool		X
Difficulty swallowing		X
Loss of appetite		X
Persistent nausea		X
Bloating	Sometimes	
Abdominal pain		X
Acid reflux		X
Recent change in bowel habit		X
Weight loss – unexpected		X
Black tarry stools		X

Metabolism

Yes No

Excessive Thirst		
Cannot skip meals		
Headache if meal is missed		
Craving for sugar and carbs		
Mid-afternoon drowsiness		
Low energy periods relieved with food		
Jittery/irritable episodes – relieved with food		
Alt. bet. high/low moods		
Alt. bet. sluggish/high energy		
High blood pressure		
Skin tags at neck/armpits		
High cholesterol/triglycerides		
Increased fat around abdomen		
Prone to inflammation		

Immune System

Yes No

Frequent colds or flu		
Rash across face and cheeks		
Patchy red rash on body		
Arthritis in fingers/hands		
Asthma/Wheezing		
Patchy hair loss		

Urinary

Yes No

Blood in urine		X
Urgent urination	X	
Frequent urination		X

Hypersensitivity

Yes No

Symptoms are year-round	X	
Symptoms are seasonal		X
Recurrent canker sores		X
Diarrhea alt. with constipation		X
Dandruff/itchy scalp		X
Eczema/Dermatitis		X
Dizziness		X
Wheezing		X
Chronic cough		X
Sinus congestion		X
Nasal congestion		X
Excessive mucus		X

Neuro-Cognitive/Psych

Yes No

Loss of self-esteem		X
Feeling of hopelessness	Sometimes	
Feeling defeated	Sometimes	
Loss of confidence		X
Mood swings	Sometimes	
Sense of powerlessness		X
Decreased sense of well-being		X
Apathy/losing interest in life		X
Vision deteriorating		X
Hearing deteriorating		X
Memory deteriorating		X
Balance deteriorating	X	
Coordination deteriorating		X
Change in headaches		X
Double vision		X
Dizzy/spinning		X

Other

Yes No

Unusual bruising		
Nose bleeds		X
Prolonged bleeding		X