AVALON
NATURAL MEDICINE

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1. **Please enter your information.**

First Name: _____ Middle Initials: _____ Last Name: _____

Preferred name (if different from legal name): _____ Date of Birth: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email Social Security Number: _____

2. Insurance Company: _____ Policy #: _____ Group #: _____

Name of Insured: _____ Relation to Insured: _____

3. **Person to call in case of Emergency:**

Name: _____ Relationship: _____ Phone number: _____

4. **Are you currently receiving healthcare elsewhere?**

○ Yes
○ No

5. **Please list your health care team:**

_____

6. **Last blood work and where it was drawn:**

_____

7. List your single most important health concern:

8. How committed are you to making changes?

## Social history

9. Sex assigned at birth:

Gender:

Sexual Orientation:

Marital Status:

10. Do you have any children?

- Yes
- No

11. If yes, please list their ages:

| | Name(s) | Age(s) |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

12. Pets?

Spiritual practice?

Yes No

## Symptoms:

## 13. Toxin Exposure

| | Y | N |
|---|---|---|
| Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials? | ☐ | ☐ |
| Have you ever had health problems following home refurbishing? | ☐ | ☐ |
| Do you experience symptoms with fragrances? | ☐ | ☐ |
| Do you use pesticides, herbicides, other chemicals around your home? | ☐ | ☐ |

## 14. General

| | Y | N |
|---|---|---|
| Fever | ☐ | ☐ |
| Chills | ☐ | ☐ |
| Fatigue | ☐ | ☐ |
| Weight change | ☐ | ☐ |
| Poor appetite | ☐ | ☐ |
| Night sweats | ☐ | ☐ |

## 15. Eyes

Date of last eye exam:

_____

Glasses/Contacts
○ Yes ○ No

Poor night vision
○ Yes ○ No

Sensitivity to light
○ Yes ○ No

Dark under eyelid
○ Yes ○ No

Blurry vision
○ Yes ○ No

Dry
○ Yes ○ No

Itchy
○ Yes ○ No

Watery
○ Yes ○ No

Discharge
○ Yes ○ No

Strain
Yes No

Styes
Yes No

Cataracts
Yes No

Glaucoma
Yes No

## 16. Head

| | Y | N |
|---|---|---|
| Headache | ☐ | ☐ |
| Migraine | ☐ | ☐ |
| Head injury | ☐ | ☐ |
| Dandruff | ☐ | ☐ |
| Dry hair | ☐ | ☐ |
| Oily hair | ☐ | ☐ |

## 17. Ear

| | Y | N |
|---|---|---|
| Hearing changes | ☐ | ☐ |
| Sensitivity to sound | ☐ | ☐ |
| Ringing | ☐ | ☐ |
| Earache | ☐ | ☐ |
| Infections | ☐ | ☐ |
| Discharge | ☐ | ☐ |

## 18. Nose

| | Y | N |
|---|---|---|
| Seasonal allergies | ☐ | ☐ |
| Post nasal drip | ☐ | ☐ |
| Congestion | ☐ | ☐ |
| Polyps | ☐ | ☐ |
| Nosebleeds | ☐ | ☐ |
| Frequent colds | ☐ | ☐ |

## 19. Mouth/Throat

Date of last dental exam:

_____

Canker sores
Yes No

Cold sores
Yes No

Cavities
Yes No

Dentures
Yes No

Gum disease
Yes No

Loss of taste
Yes No

Sore throat
Yes No

Difficulty swallowing
Yes No

Hoarseness
Yes No

## 20. Respiratory

| | Y | N |
|---|---|---|
| Painful breathing | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Cough | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Lung infections | ☐ | ☐ |

## 21. Cardiovascular

| | Y | N |
|---|---|---|
| Chest pain | ☐ | ☐ |
| Arrythmias | ☐ | ☐ |
| Palpitations | ☐ | ☐ |
| Murmurs | ☐ | ☐ |
| Edema | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ |

**22.** Bowel movement frequency:

Date of last colonoscopy:

## 23. Gastrointestinal

| | Y | N |
|---|---|---|
| Constipation | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Heartburn | ☐ | ☐ |
| Indigestion | ☐ | ☐ |
| Bloating | ☐ | ☐ |
| Nausea | ☐ | ☐ |
| Vomiting | ☐ | ☐ |
| Ulcer | ☐ | ☐ |
| Pancreatitis | ☐ | ☐ |
| Liver disease | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ |
| Gallbladder disease | ☐ | ☐ |

## 24. Pelvic Organs/Urinary

| | Y | N |
|---|---|---|
| Sexually active | ☐ | ☐ |
| Contraception | ☐ | ☐ |
| Poor Libido | ☐ | ☐ |
| STI/STD | ☐ | ☐ |
| Painful intercourse | ☐ | ☐ |
| Discharge | ☐ | ☐ |
| Urgency | ☐ | ☐ |
| Pain with urination | ☐ | ☐ |
| Blood in urine | ☐ | ☐ |
| Kidney stones | ☐ | ☐ |
| Frequent urinary infection | ☐ | ☐ |
| Hernia | ☐ | ☐ |
| Testicular bumps/swelling | ☐ | ☐ |
| Testicular pain | ☐ | ☐ |
| Self-testicular exam | ☐ | ☐ |
| Erection problems | ☐ | ☐ |
| Abnormal PSA | ☐ | ☐ |
| Enlarged Prostate | ☐ | ☐ |
| Prostate cancer | ☐ | ☐ |

**25.** Color of urine:

_____

## 26. Gynecology

Age periods began _____

Frequency of menses _____

Length of menses _____

1st day of last menses _____

Date of last mammogram (if applicable) _____

Age when you entered menopause (if applicable) _____

How old was your mother when she entered menopause? _____

Number of pregnancies _____

Number of births _____

Last pap date _____

Was your last pap abnormal?
○ Y ○ N

27.

| | Y | N |
|---|---|---|
| Self-breast exams | ☐ | ☐ |
| Breast implants | ☐ | ☐ |
| Infertillity | ☐ | ☐ |
| Use of hormones | ☐ | ☐ |
| Vaginal dryness | ☐ | ☐ |
| Vaginitis | ☐ | ☐ |
| PMS symptoms | ☐ | ☐ |
| Heavy menstrual bleeding | ☐ | ☐ |
| Severe menstrual cramping | ☐ | ☐ |

28. **Musculoskeletal:**

| | Y | N |
|---|---|---|
| Back/Neck pain | ☐ | ☐ |
| Weakness | ☐ | ☐ |
| Morning stiffness | ☐ | ☐ |
| Joint pain | ☐ | ☐ |
| Joint swelling | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Muscle pain | ☐ | ☐ |
| Muscle cramps | ☐ | ☐ |
| Tremors | ☐ | ☐ |
| Fractures | ☐ | ☐ |
| Joint fusions | ☐ | ☐ |

## 29. Nervous

| | Y | N |
|---|---|---|
| Burning/tingling | ☐ | ☐ |
| Loss of sensation | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| Falling | ☐ | ☐ |
| Paralysis | ☐ | ☐ |
| Vertigo/Dizzines | ☐ | ☐ |
| Difficulty speaking | ☐ | ☐ |

## 30. Skin

| | Y | N |
|---|---|---|
| Rash | ☐ | ☐ |
| Hives | ☐ | ☐ |
| Psoriasis | ☐ | ☐ |
| Eczema | ☐ | ☐ |
| Dry | ☐ | ☐ |
| Itchy | ☐ | ☐ |
| Stretch marks | ☐ | ☐ |
| Color change | ☐ | ☐ |
| Warts | ☐ | ☐ |
| Moles | ☐ | ☐ |
| Lump | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Excess sweat | ☐ | ☐ |
| White spots on nails | ☐ | ☐ |
| Sensitive to cheap metal, shirt tags, or rough textured fabrics? | ☐ | ☐ |

## 31. Endocrine

| | Y | N |
|---|---|---|
| Hair loss | ☐ | ☐ |
| Cold intolerance | ☐ | ☐ |
| Excess hunger | ☐ | ☐ |
| Excess thirst | ☐ | ☐ |
| Dizzy when standing up | ☐ | ☐ |
| Excess urination | ☐ | ☐ |

## 32. Describe your:

Focus/Concentration:

Memory/Recall:

Comprehension: