

Confidential Patient History

Legal Name _____ Name you preferred to be called _____

Address _____ City _____ State _____ Zip _____

Home (_____) _____ Work (_____) _____ Mobile (_____) _____

Sex: Male Female Age _____ DOB _____ Social Security _____ - _____ - _____

Email _____

Occupation _____ Employer _____

Names/Ages of Children _____

Marital Status: Single Married Widowed Divorced Other _____

Name of Partner _____ Partner's Employer _____

Name of Emergency Contact _____ Relationship _____

Best Number to Contact Them Mobile Home Work Other (_____) _____

How did you hear about Dr. Hamel? _____

Do you have health insurance? Yes No If you checked yes, please provide us with a copy of your insurance ID card(s).

Name of the insured _____ Insured's date of birth _____

What is their relationship to you? Spouse Child Other _____

Do they live at the same address as you? Yes No

If you checked no, what is their address _____ City _____ State _____

Zip _____ Phone Number (_____) _____ Do you want to be added to Dr. Hamel's

Newsletter? Y N

Nutritional, Metabolic & Structural Evaluation

Please complete the following information as completely as possible. This helps us to address your concerns and needs, and to build a health program personally designed for you.

Complaints | Please rank your health complaints and rate their severity (on a scale from 1-10, 10 being the worst).

Other Information | Please tell us any additional information or concerns about your health.

Goals | What are your goals for seeing Dr. Hamel?

Limitations | What limitations do you have, if any, in working with Dr. Hamel? (e.g. unwilling to take nutritional supplements, working in excess of 60 hours a week, won't give up smoking or alcohol, etc).

Stress Level | Rate your stress level currently on a scale from 1-10 (10 being the most stress). Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, road rage, not happy with life, depression, etc.

Overall stress: _____ Main reasons for stress _____

If over a level 5, what steps are you currently taking to reduce your stress?

Energy Level | List on a scale from 1-10 (1 is lowest, 10 is highest) what is your energy level during the following times:

AM _____ Afternoon _____ Evening _____ Late PM _____ After meals _____ Overall _____

Sleep Quality | How is your sleep? (check all that apply) Restful Restless Hard to get sleep Wake up often Nightmares

What time do you usually go to sleep? _____ Hours of sleep/night? _____

Type of mattress? _____ How old is it? _____ Type of pillows, sheets, and blankets? _____

Exercise | Do you exercise? _____ How often? _____ For how long per session? _____

What type of exercise do you do? _____

Medical History | Please describe any conditions which are under the care of a physician.

Diagnosis _____

Date of onset _____ Duration of current symptoms _____

Doctor(s) involved, their specialty _____

How diagnosed (what tests)? _____

Current treatment (medication, etc.) _____

Treatment received in past, if any, and how it worked _____

Medications | Please list any medications you are taking, or have taken in the past, and for how long. State the reason for taking it.

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Diuretics | <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Steroids (prednisone, anabolic, cortisone) |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Hormones (estrogen, progesterone, DHEA, testosterone, thyroid) | <input type="checkbox"/> Pain Killers | |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Blood Pressure Meds | | <input type="checkbox"/> Parasite Medication | <input type="checkbox"/> Yeast/Fungal Meds |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Cardiac/Heart Meds | | | |

Drugs | This is strictly confidential. Please list any recreational drugs used now or in the past: _____

How often? _____ How long? _____

Surgeries/Hospitalizations | What surgeries, operations, traumas, fractures, car accidents, etc. have you had?

- | | | | | |
|---|--|-------------------------------------|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Breast Implants | <input type="checkbox"/> C-Sections | <input type="checkbox"/> Plastic or metal inside your body | <input type="checkbox"/> Implants/Prostheses |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Biopsies | <input type="checkbox"/> D&Cs | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Body piercings | | | <input type="checkbox"/> Tonsils/Adenoids |

Other (please list all with brief details such as date, outcome, etc.) _____

Scars | Describe any scars on your body (major and minor ones) _____

Smoking | Do you currently smoke? _____ How much? _____ How long? _____

Dental Work | Indicate how many of the following you have:

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Silver fillings _____ | <input type="checkbox"/> Composites _____ | <input type="checkbox"/> Bleeding gums _____ | <input type="checkbox"/> Dentures _____ | <input type="checkbox"/> Porcelain crowns _____ |
| <input type="checkbox"/> Root canals _____ | <input type="checkbox"/> Grinded/worn teeth _____ | <input type="checkbox"/> Veneers _____ | <input type="checkbox"/> Sensitive teeth _____ | <input type="checkbox"/> Gold crowns _____ |
| <input type="checkbox"/> Extractions _____ | | <input type="checkbox"/> Posts _____ | <input type="checkbox"/> Temporaries _____ | <input type="checkbox"/> Steel crowns _____ |
| <input type="checkbox"/> Implants _____ | <input type="checkbox"/> BioCalex root canals _____ | <input type="checkbox"/> Extractions _____ | <input type="checkbox"/> Infections/pockets _____ | |
| | | <input type="checkbox"/> New cavities _____ | | |

Do you need further dental work? _____ If so, what? _____

Sunlight | Amount of natural sunlight you receive daily outside? _____

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Hours spent daily under fluorescent light? _____ Hours of sunlight daily through windows? _____

Clothing | How often do you wear 100% natural clothing (cotton, ramie, wool, silk, linen)? _____

How often to you wear 100% synthetic clothing (polyester, acrylic, nylon, rayon, etc.)? _____ Blends? _____

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal		Paternal		Mother	Father	Brother	Sister	Onset	Outcome
	Grandma	Grandpa	Grandma	Grandpa						
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other	_____									

Review of Systems | Please check the “NOW ” box for all conditions that you are now experiencing and mark the “PAST” box for any condition or symptoms experienced at any time in your life.

	N	P		N	P		N	P		N	P
General			Nose			G-I System			Neurologic		
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Head			Lungs			Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
Blacking out	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Bone		
Eyes			Coughing phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscle ache	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Vascular			Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	G-U System			Bone pain	<input type="checkbox"/>	<input type="checkbox"/>
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Mouth			Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Cold feet/hands	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Skin		
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Calf pain	<input type="checkbox"/>	<input type="checkbox"/>	Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Increased urination	<input type="checkbox"/>	<input type="checkbox"/>	Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>	Changes in moles	<input type="checkbox"/>	<input type="checkbox"/>
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness						Genital infection	<input type="checkbox"/>	<input type="checkbox"/>	Peeling	<input type="checkbox"/>	<input type="checkbox"/>

Bowel Movements | Please circle those that apply.

How often: daily | more than once a day | skip days Consistency: normal | too hard | too soft | diarrhea alternating with hard

Amount: normal | too little Color: brown | black | yellow | whitish Other: mucus | foul smell | lots of gas

Comments: _____

Female Specific Issues | Please circle those that apply and fill in the blanks.

Are you pregnant? Y N Going through menopause? Y N Have your periods stopped? Y N

Breast feeding? Y N Are your periods regular? (28 day cycle) Y N Do you have monthly periods? Y N

Date of your last menstrual period? _____ Have you had a hysterectomy (indicate date, partial or total):

_____ Have you been diagnosed with any of the following (circle) : endometriosis, PCOS, fibroids,

PMS, dysmenorrhea, menorrhagia, infertility. Have you had any miscarriages? Y N

Emotional Tendency | Please check those emotions that you have a tendency towards.

Anger Anxiety Criticism Fear Insecurity Worry Inability to forgive (self/others) Other _____

Toxic Inventory / Personal Care Products | Please list any toxins, chemicals, or solvents you have had exposure to or use of. These can include products for the yard, work, furniture, art, building/carpentry, etc. (list the brand names in the space provided):

- | | | |
|--|--|--|
| <input type="checkbox"/> Shampoo _____ | <input type="checkbox"/> Deodorant _____ | <input type="checkbox"/> Toothpaste _____ |
| <input type="checkbox"/> Body Soap _____ | <input type="checkbox"/> Hand/Body Lotion _____ | <input type="checkbox"/> Laundry Soap _____ |
| <input type="checkbox"/> Dish Soap _____ | <input type="checkbox"/> Household Cleaner _____ | <input type="checkbox"/> Hairspray/Gel _____ |
| <input type="checkbox"/> Nail Polish _____ | <input type="checkbox"/> Hair Coloring _____ | <input type="checkbox"/> Air Freshener _____ |
| <input type="checkbox"/> Ant/Roach Spray _____ | <input type="checkbox"/> Pesticides _____ | <input type="checkbox"/> Other _____ |

Electromagnetic Exposure | How many hours do you spend daily:

- | | | |
|--|--|---|
| <input type="checkbox"/> Watching TV _____ | <input type="checkbox"/> Talking on a cell phone _____ | <input type="checkbox"/> Near electrical equipment _____ |
| <input type="checkbox"/> Wearing a pager _____ | <input type="checkbox"/> Working on a computer _____ | <input type="checkbox"/> Sleeping near an electric clock? _____ |

Water/Hydration | How many glasses (8-10 oz) of plain water do you drink in an average day? ____ Do you drink tap water? ____

What brand(s) of drinking water do you use? _____

Do you cook with tap, bottled, or filtered water on a regular basis? _____

If you have a home water purifier, when was the last time you changed the cartridge? _____

Diets | Please check any applicable diet that you are currently on.

- | | | | | |
|---|-------------------------------------|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Allergy rotation/desensitization | <input type="checkbox"/> No dairy | <input type="checkbox"/> Vegan | <input type="checkbox"/> Low fat | <input type="checkbox"/> Any other diet _____ |
| <input type="checkbox"/> Atkins/Zone diet | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Yeast-free | <input type="checkbox"/> Diabetic | |
| <input type="checkbox"/> Candida diet | <input type="checkbox"/> Low salt | | | |

Food Habits | How often do you eat out, and at what type of restaurants? _____

How often do you prepare meals at home? _____ Do you avoid food/drinks that list "natural flavors" on the label? _____

Please check if you do any of the following:

- Eat while working, watching TV, driving, etc. Eat food past 7pm Eat/chew food too fast Skip meals often (which ones) _____

Food Choices | Please check each type of food you eat twice a week or more. (C=commercially grown, O=organically grown)

Premade Foods	Harvest	Meat/Fish	Dairy	Condiments
C O	C O	C O	C O	C O
Canned foods <input type="checkbox"/> <input type="checkbox"/>	Fresh vegetables <input type="checkbox"/> <input type="checkbox"/>	Beef, pork, lamb <input type="checkbox"/> <input type="checkbox"/>	Eggs <input type="checkbox"/> <input type="checkbox"/>	Table salt <input type="checkbox"/> <input type="checkbox"/>
Boxed cereal <input type="checkbox"/> <input type="checkbox"/>	Fresh fruit <input type="checkbox"/> <input type="checkbox"/>	Chicken <input type="checkbox"/> <input type="checkbox"/>	Butter <input type="checkbox"/> <input type="checkbox"/>	Sea salt <input type="checkbox"/> <input type="checkbox"/>
Frozen dinners <input type="checkbox"/> <input type="checkbox"/>	Whole grains <input type="checkbox"/> <input type="checkbox"/>	Turkey <input type="checkbox"/> <input type="checkbox"/>	Milk <input type="checkbox"/> <input type="checkbox"/>	Ketchup <input type="checkbox"/> <input type="checkbox"/>
Frozen juices <input type="checkbox"/> <input type="checkbox"/>	Whole beans <input type="checkbox"/> <input type="checkbox"/>	Canned tuna <input type="checkbox"/> <input type="checkbox"/>	Milk, raw <input type="checkbox"/> <input type="checkbox"/>	Mustard <input type="checkbox"/> <input type="checkbox"/>
Take-out food <input type="checkbox"/> <input type="checkbox"/>		Fresh fish <input type="checkbox"/> <input type="checkbox"/>	Cheese <input type="checkbox"/> <input type="checkbox"/>	Vinegar <input type="checkbox"/> <input type="checkbox"/>
		Frozen fish <input type="checkbox"/> <input type="checkbox"/>		Sweetener <input type="checkbox"/> <input type="checkbox"/>
		Restaurant fish <input type="checkbox"/> <input type="checkbox"/>		

Food Stressors | Please check which of the following you have every week & indicate how many times per week you consume it.

Stimulants	Toxic Oils	Hormone Platters (non-organic)	Empty/Processed
Coffee (inc. decaf) <input type="checkbox"/> _____	Fried foods <input type="checkbox"/> _____	Beef <input type="checkbox"/> _____	White pasta <input type="checkbox"/> _____
Black tea, chai tea <input type="checkbox"/> _____	Fast foods <input type="checkbox"/> _____	Chicken <input type="checkbox"/> _____	White bread <input type="checkbox"/> _____
Soft drinks (cola, etc.) <input type="checkbox"/> _____	Potato or corn chips <input type="checkbox"/> _____	Milk, Ice cream <input type="checkbox"/> _____	Instant cereal <input type="checkbox"/> _____
Drinks w/NutraSweet <input type="checkbox"/> _____	Roasted nuts <input type="checkbox"/> _____	Cheese, butter <input type="checkbox"/> _____	Cookies <input type="checkbox"/> _____
Alcohol <input type="checkbox"/> _____	Smoked meats <input type="checkbox"/> _____	Yogurt <input type="checkbox"/> _____	Store-bought muffins <input type="checkbox"/> _____
Chocolate <input type="checkbox"/> _____	Margarine <input type="checkbox"/> _____	Hot dogs/sausage <input type="checkbox"/> _____	Minute rice <input type="checkbox"/> _____
Candy, pastry, sweets <input type="checkbox"/> _____	Shortening <input type="checkbox"/> _____	Pork, lunch meats <input type="checkbox"/> _____	Bagels <input type="checkbox"/> _____

Signature _____ Date _____