Vital Life Medicine

Jodi Berger, ND, LMT

www.vitallifemedicine.com

E: drjodi@vitallifemedicine.com

T: (425) 268-8057

MALE Adult

Welcome to Vital Life Medicine! In order to provide you with the best possible care, we ask you to complete this form in its entirety. It will be greatly appreciated if you can either mail (with sufficient time) or email this form prior to your appointment so that Dr. Berger can review your health history ahead of time. Thank you!

PERSONAL INFORMATION

Name:_____Date: _____

Address: _____

Telephone: (Home): _____(Work): _____(Cell): _____

May I leave confidential voice-mail messages for you at any of the above numbers? Y / N (specify): H / W / C

E-mail Address: _____

May I leave confidential email messages for you at the above address? Y / N

Age: _____Date of Birth: _____Birth Gender: F M GN Identified Gender: F M GN

Married_____ Separated_____ Divorced_____ Widowed_____ Single_____ Partnership_____

Live with: Spouse_____ Partner_____ Parents_____ Children_____Friend/s_____ Alone_____Other_____

Occupation:_____ Hours per week:_____

Employer Name:_____

Employer Address:_____

Have you ever seen a Naturopathic Physician before? Y / N If so, who? _____

How did you hear about this Vital Life Medicine? _____

May we thank them for the referral? Y / N

If Internet: Google____ Website_____ Other_____

Has any other family member been seen at my practice? Y / N

Emergency Contact:_____ Relationship:_____

Phone:_____ Address:_____

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CONTEXT OF CARE REVIEW

Successful health care, wellness and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me in assisting your health needs.

Why did you choose to come to Vital Life Medicine?

What do you know about my approach?

What three expectations do you have from **this visit** to Vital Life Medicine?

What **long-term** expectations do you have from working with Dr. Jodi Berger, ND, LMT?

What expectations do you have of me personally as your health care provider?

Circle what is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits?

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols, which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you love to do?

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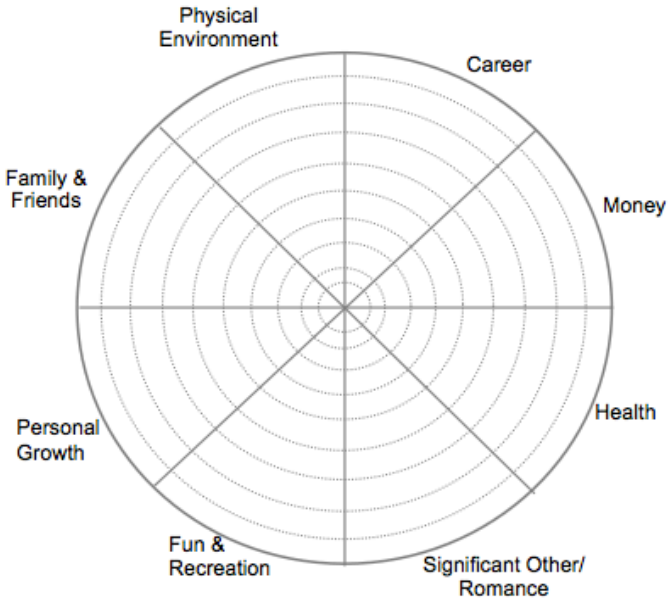
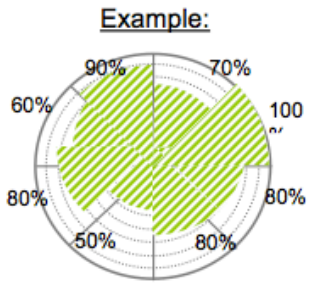
Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.





CURRENT HEALTH HISTORY

Are you currently receiving healthcare? Y / N

If **yes**, for what and from whom?_____

_____

If **no**, when and where did you last receive medical health care?_____

_____

What was the reason?_____

What are your **most important health concerns**? List as many as you can in order of importance.

1) _____

2) _____

3) _____

Do you have any known contagious diseases at this time? Y / N

If yes, what?_____

Have you ever received a blood transfusion? Y / N

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FAMILY HISTORY

Do you or anyone in your family have a history of any of the following conditions? (Please circle and note who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hay fever/Hives	Allergies	Osteoporosis	Eczema
Irritable Bowel Disorder	Alcoholism		

Any other relevant family history?_____

What is your family heritage?_____

If anyone in your immediate biological family has passed away, please indicate their age at time of death, as well as the cause of death._____

_____

CHILDHOOD ILLNESSES

Weight at Birth:_____

Please circle whether you had any of the following as a child:

Chicken pox	Diphtheria	German Measles
Measles	Mononucleosis	Mumps
Rheumatic Fever	Rubella	Scarlet Fever

IMMUNIZATIONS HISTORY

Circle all immunizations you've received and write date when you last received them.

Chickenpox/Varicella	Hepatitis A	Meningococcal
Flu (Influenza)	Hepatitis B	Measles/Mumps/Rubella (MMR)
Gardasil/HPV	Zostavax (Shingles)	Tdap (Tetanus, Diphtheria, Pertussis)
Polio	Tetanus	

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HOSPITALIZATIONS, SURGERY, IMAGING

What hospitalizations, surgeries, X-rays, CAT scans, MRI's, EEG, and/or EKG's have you had?

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

ALLERGIES

Are you hypersensitive or allergic to...

Any drugs?_____

Any foods?_____

Any environmental or chemicals?_____

EXPOSURES

Have you had daily or prolonged exposure to any toxic chemicals, paints, lead, or mercury? Y / N

If **yes**, what type and when?_____

Second hand smoke? Y / N For how long?_____

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Antacids	Antibiotics	Appetite Suppressants	Birth Control Pills
Cortisone	Hormone Replacement	Laxatives	Pain Relievers
Sleeping Pills	Thyroid Medication	Tranquilizers	

Please list **ANY** prescription medications, over the counter medications, vitamins, or other supplements you are currently taking or use frequently. Include the dosage.

GENERAL

Height:_____ Weight:_____lbs. Weight 1 year ago:_____lbs.

Maximum Weight:_____ When:_____

Rate your energy (1-10, 10 = most energy):_____ Is this a change? Y / N

At what time of the day is your energy at its best?_____ Worst?_____

Please rate your stress level on a scale of 1-10 (10 = most stress):_____

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TYPICAL FOOD INTAKE

Do you follow a specific diet? Y / N Please explain:_____

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Do you eat 3 meals a day? Y / N

Do you cook your own meals? Y / N

Do you drink caffeinated beverages? Y / N

Do you go on diets often? Y / N

Do you eat the following?

Eggs Y / N	Red Meats Y / N	Chicken Y / N
Fish Y / N	Milk Y / N	Cheese Y / N
Bread Y / N	Yogurt Y / N	Butter Y / N
Margarine Y / N	Added Salt Y / N	Cooked Vegetables Y / N
Potato/Yam Y / N	Fruits Y / N	Salads Y / N
Sugar Y / N	Nuts & Seeds Y / N	

List any foods that you crave:_____

_____

List any foods that you react to:_____

_____

HABITS

Main interests and hobbies?_____

Do you exercise? Y / N If yes, what kind and how often?_____

_____

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FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you have now or yes N = Never had or no P = Significant problem in the past

Average 6-8 hours of sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch TV?	Y N Hrs=
Have a history of abuse?	Y N P	Read?	Y N Hrs=
Any major traumas	Y N P	Religious/spiritual practice?	Y N P What?
Use recreational drugs?	Y N P	Smoked previously?	Y N
		How many years?	How many packs/day?
Been treated for drug dependence?	Y N P	Use alcoholic beverages?	Y N P
Do you currently use tobacco?	Y N		

MENTAL / EMOTIONAL

Treated for emotional problem/s?	Y N P	Depression? Seasonal?	Y N P
Anxiety or nervousness?	Y N P	Poor concentration?	Y N P
Mood swings?	Y N P	Considered/Attempted suicide?	Y N P
Tension?	Y N P	Memory problems?	Y N P

NEUROLOGIC

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Vertigo or lightheadedness?	Y N P	Loss of balance?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P

ENDOCRINE

Thyroid problem? Hypo- / Hyper-	Y N P	Heat or cold intolerance?	Y N P
Low blood sugar (hypoglycemia)?	Y N P	Diabetes?	Y N P
Excessive thirst or hunger?	Y N P	Fatigue?	Y N P
Hair loss?	Y N P	Exercise intolerance?	Y N P

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IMMUNE

Reactions to immunizations?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P
Night sweats?	Y N P	Chronic fatigue syndrome?	Y N P
Auto-immune disease?	Y N P	Cancer?	Y N P

SKIN

Rashes, eczema or hives?	Y N P	Itching?	Y N P
Change in skin color?	Y N P	Acne/boils?	Y N P
Lumps or bumps on skin?	Y N P	Perpetual hair loss?	Y N P
Brittle nails?	Y N P	Dry skin?	Y N P

HEAD

Headaches?	Y N P	Head injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P

EYES

Impaired vision?	Y N P glasses or contacts	Cataracts?	Y N P
Color blindness?	Y N P	Glaucoma?	Y N P
Tearing or dryness?	Y N P	Eye pain/strain?	Y N P
Spots in vision?	Y N P	Double vision?	Y N P

EARS

Impaired hearing?	Y N P	Ringing in ears?	Y N P
Earaches?	Y N P	Ear infections?	Y N P

NOSE & SINUSES

Frequent colds?	Y N P	Nose bleeds?	Y N P
Congestion?	Y N P	Hay fever?	Y N P
Loss of smell?	Y N P		

MOUTH & THROAT

Frequent sore throat?	Y N P	Sores in mouth?	Y N P
Teeth grinding?	Y N P	Dental cavities?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Sore tongue or lips?	Y N P	Jaw clicking?	Y N P

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NECK

Swollen glands or lumps?	Y N P	Pain or stiffness?	Y N P
Difficulty swallowing?	Y N P	Goiter?	Y N P

RESPIRATORY

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Asthma or wheezing?	Y N P
Pneumonia?	Y N P	COPD?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Bronchitis?	Y N P	Tuberculosis?	Y N P
Emphysema?	Y N P	Shortness of breath lying down?	Y N P

CARDIOVASCULAR / BLOOD / PERIPHERAL VASCULAR

Heart disease?	Y N P	Chest pain/angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Palpitations/Fluttering?	Y N P
Vascular disorder?	Y N P	Swelling/edema in ankles?	Y N P
Rheumatic fever?	Y N P	Fainting?	Y N P
Heart attack or stroke?	Y N P	Phlebitis/deep leg pain?	Y N P
Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Cold hands/feet?	Y N P	Varicose veins?	Y N P

Date of last routine blood work:

URINARY

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P
Abnormal urine color/odor?	Y N P	Kidney disease?	Y N P

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GASTROINTESTINAL

Trouble swallowing?	Y N P	Heartburn?	Y N P
Abdominal pain/cramps?	Y N P	Nausea/vomiting?	Y N P
Belching or passing gas?	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements:	How often? Is this a change?
Gall bladder disease?	Y N P	Black stools?	Y N P
Liver disease?	Y N P	Blood in stool?	Y N P
Hemorrhoids?	Y N P	Pancreatitis?	Y N P
Change in appetite? Change in thirst?	Y N P Y N P	Had a colonoscopy? Date:	Y N Abnormal? Y / N

MUSCULOSKELETAL

Joint pain/stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms/cramps?	Y N P	Sciatica?	Y N P

MALE REPRODUCTIVE

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Sexually transmitted infection? Y N P If yes, circle type: Chlamydia, Gonorrhea, Syphilis, Herpes		Discharge or sores?	Y N P
Are you sexually active?	Y N P	Premature ejaculation?	Y N P
Impotence?	Y N P	Sexual orientation:	
Birth control? Y / N	Type?	BPH?	Y N P
Low sex drive?	Y N P	Fertility issues?	Y N P
Prostate exam? Date:	Y N Abnormal? Y N	PSA check? Date:	Y N Abnormal? Y N

Is there anything else you would like to add or comment on? (Please use additional sheets if necessary.)

Thank you for your time and effort.
I look forward to working with you in your healing process.
If you have any questions please ask!
~ Dr. Berger

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Vital Life Medicine Policies

In order to establish clear communication between the patient and Dr. Berger, the following outlines the policies at Vital Life Medicine (VLM).

Fees and Payment:
You have a right to ask what these fees are prior to the visit. Payment for services are due at the time of the visit. Payment may be made by cash, check, or Venmo.

Returned Check Fee:
Returned checks will be subject to a $35.00 non-sufficient funds fee.

Insurance:
Naturopathic medicine is not a licensed profession in the state of Texas and therefore insurance is not applicable. If you are interested in changing that please contact the Texas Association of Naturopathic Doctors to get involved.

Appointment Cancellations:
When you make an appointment, we reserve that time specifically for you. If you must cancel an appointment, we ask that you give us at least 24 hours' notice. No-shows or appointments cancelled inside of 24 hours result in a charge of $50.00, emergencies excluded.

If you have any questions regarding these guidelines, please ask.

By signing below, I acknowledge that I have read and understand the above-stated policies of Vital Life Medicine and will comply with them in all respects.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor) Date

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E-Mail Agreement

Vital Life Medicine may use e-mail to correspond with patients as a convenience.

I have been advised that:

E-mail is never, ever appropriate for urgent or emergency problems.

E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.

E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.

There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.

All e-mail correspondence will become a part of my medical record at Vital Life Medicine.

It is extremely important to include my name on each and every e-mail sent to Dr. Berger.

Since e-mail may not be monitored while Dr. Berger is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within one week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between myself and Vital Life Medicine, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at anytime by contacting Vital Life Medicine.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print e-mail address clearly:_____

Printed Name:_____

Signature:_____ Date:_____