
Dr. Roxie Strand, NMD

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # home: _____ work: _____ cell: _____

E-mail address: _____

Age: ____ Date of Birth: _____ Gender: female ____ male ____

Education: _____

Married: ____ Separated: ____ Divorced: ____ Widowed: ____ Single: ____ Partnership: ____

Live with: Spouse __ Partner __ Parents __ Children __ Friends ____ Alone ____

Occupation: _____ Hours per week: _____ Retired: _____

Employer: _____ S.S.#: _____

(Work address): _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Person to reach in case of an emergency: _____

Relationship: _____ Phone: _____

Address: _____

PLEASE FILL OUT EACH PAGE AS FULLY AS POSSIBLE

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses 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 to assist your health needs.

1) Why did you choose to come to Creative Healing Solutions?

What do you know about our approach to healing?

2) What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

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

4) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits? (please list)

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

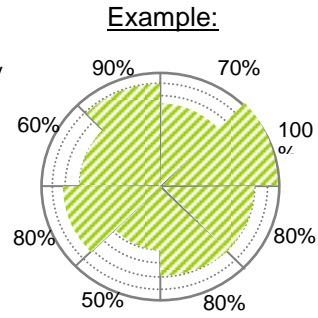
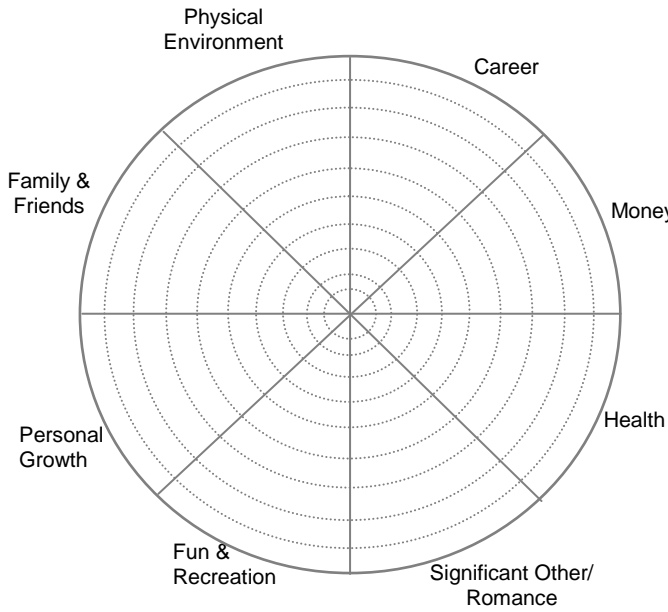
6) Who in your life will support you with the lifestyle changes you will be making?

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.



Are you currently receiving healthcare? Y N

If yes, where and from whom: _____

If no, when and where did you last receive medical or 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) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Family History

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease	Arthritis
Kidney Disease	Epilepsy	High Blood Pressure	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hayfever/Hives			

Any other relevant family history? _____

What is your heritage: _____

Childhood Illnesses

Please circle whether you had any of these as a child:

Scarlet fever	Diphtheria	Rheumatic fever	Chicken Pox
Mumps	Measles	German measles	

Hospitalization, Surgery, Imaging

List any hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's you have had:

_____ year: _____	_____ year: _____
_____ year: _____	_____ year: _____
_____ year: _____	_____ year: _____

Allergies

Are you hypersensitive or allergic to:

Any Rx meds/drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

Current Medications

Do you take or use:

Laxatives	Y N	Pain relievers	Y N
Antacids	Y N	Cortisone	Y N
Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N
Sleeping pills	Y N	Hormone Therapy	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) _____	5) _____
2) _____	6) _____
3) _____	7) _____
4) _____	8) _____

REVIEW OF SYSTEMS

Y=a condition you have now

N=Never had

P=Significant problem in the past

Mental / Emotional

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

Immune

Reactions to immunizations?	Y	N	P	Reactions to vaccinations?	Y	N	P
Chronic Fatigue Syndrome?	Y	N	P	Chronic infections?	Y	N	P
Chronically swollen glands?	Y	N	P	Slow wound healing?	Y	N	P

Endocrine

Hypothyroid?	Y	N	P	Heat or cold intolerance?	Y	N	P
Hypoglycemia?	Y	N	P	Diabetes?	Y	N	P
Excessive thirst?	Y	N	P	Excessive hunger?	Y	N	P
Fatigue?	Y	N	P	Seasonal depression?	Y	N	P

Neurologic

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

Skin

Rashes?	Y	N	P	Eczema, Hives?	Y	N	P
Acne, Boils?	Y	N	P	Itching?	Y	N	P
Color Change?	Y	N	P	Perpetual Hair Loss?	Y	N	P
Lumps?	Y	N	P	Lesions?	Y	N	P

Head

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

Eyes

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

Ears

Impaired hearing?	Y	N	P	Ringing?	Y	N	P
Earaches?	Y	N	P	Dizziness?	Y	N	P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	“ “ lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting?	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? _____	
Gall Bladder disease?	Y N P	Is this a change? _____	
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

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

Musculoskeletal

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

Y=a condition you have now

N=Never had

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Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Male Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Chlamydia?	Y N P
Sexual orientation: _____		Gonorrhea?	Y N P
Impotence?	Y N P	Condyloma/Warts?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control? Type? _____		Syphilis?	Y N P

Female Reproduction / Breasts

Age of first menses? _____	Date of last annual exam/ PAP _____
Age of last menses? (if menopausal) _____	Are cycles regular? Y N

Length of cycle? _____ days	Bleeding between cycles? Y N P
Duration of menses? _____ days	Pain during intercourse? Y N P
Painful menses? Y N P	Clotting? Y N P
Heavy or excessive flow? Y N P	Discharge? Y N P
PMS? Y N P	Birth control? Y N P
If yes, what are your symptoms? _____	What type? _____

Endometriosis? Y N P	Number of pregnancies: _____
Ovarian cysts? Y N P	Number of live births: _____
Difficulty conceiving? Y N P	Number of miscarriages: _____
Cervical Dysplasia? Y N P	Number of abortions: _____
Sexual difficulties? Y N P	Menopausal symptoms? Y N P
Gonorrhea? Y N P	Abnormal PAP? Y N P
Herpes? Y N P	Chlamydia? Y N P
Are you sexually active? Y N	Condyloma/Warts? Y N P
Do you do breast self exams? Y N P	Syphilis? Y N P
Breast pain/tenderness? Y N P	Sexual orientation: _____
	Breast lumps? Y N P
	Nipple discharge? Y N P

Is there anything else you would like to add or comment on?

Thank you for taking the time to fill out this history form completely. The information that you provide will significantly help me in providing you the best care possible during your health journey. I look forward to meeting you soon!



PATIENT CONSENT TO TREAT

I give my permission for Dr. Roxie Strand and her associates and staff at Creative Healing Solutions to treat me for my health care. I understand that Dr. Strand is a licensed naturopathic physician in the state of AZ and that my treatment may include, but is not limited to the modalities listed below:

- Acupuncture
- Bio-Identical Hormone Replacement Therapy
- HCG Medical Weight Loss
- Herbal Medicine
- Homeopathy
- IV Therapy
- Lifestyle Counseling
- Minor Surgical Procedures (biopsies, cryotherapy, excisions, incisions, suture removal)
- Naturopathic Manipulation Therapy
- Nutrition
- Nutritional Supplementation

I understand that some of the modalities used for my treatment may not be FDA approved and may be experimental therapies.

I understand that any prescribed treatment may have potential side effects and it is my responsibility to immediately notify my physician of any adverse side effects &/or complications of my treatment.

I understand that if I have failed in any way to provide Creative Healing Solutions with my complete and accurate medical history, or become aware of any changes in the future of which I have not notified my physician, I cannot hold the physician or Creative Healing Solutions responsible for any adverse effects that I may suffer.

I hereby state that I am 18 years of age or older. I understand that falsifying information in order to obtain prescription medication or medical care is a violation of federal and state law, so I hereby agree to answer all written & verbal questions truthfully.

I understand that it is my responsibility to notify any other physician whose present care I am also under about my treatment from Dr. Strand and Creative Healing Solutions, so that they too may accurately advise me concerning any potential conflicts in care and so that all of my healthcare providers may be able to consult regarding my medical care.

I consent to the use or disclosure of my protected medical information by Dr. Strand and Creative Healing Solutions for the purposes of diagnosing, treating, &/or obtaining payment for my healthcare.

I have read and agree to this Consent to Treat

Signature: _____ Date: _____

Print Name: _____