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ADULT INTAKE

PATIENT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE # (HOME): _____ (CELL): _____ (WORK): _____

IS IT OK TO CALL AND LEAVE A MESSAGE AT HOME? Y N ON YOUR CELL? Y N AT WORK? Y N

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.#: _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

HAS ANY OTHER FAMILY MEMBER ALREADY BEEN A PATIENT AT THE CLINIC? _____

BOZEMAN IS A SMALL TOWN. IN AN EFFORT TO MAINTAIN CONFIDENTIALITY PLEASE LET ME KNOW IF YOU WOULD LIKE TO BE ADDRESSED UPON MEETING IN PUBLIC OR REMAIN ANONYMOUS. _____

NEXT OF KIN OR OTHER TO REACH IN AN EMERGENCY: _____

RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____

CONTEXT OF CARE REVIEW

EFFECTIVE HEALTHCARE AND PREVENTATIVE MEDICINE ARE POSSIBLE WHEN THE PHYSICIAN HAS AN UNDERSTANDING OF THE PERSON AS A WHOLE – PHYSICALLY, MENTALLY, EMOTIONALLY, SPIRITUALLY. YOUR RESPONSES BELOW WILL ASSIST IN MY UNDERSTANDING OF YOUR GOALS AND DESIRES PERTAINING TO HEALTH. AS WITH ALL OF YOUR INTERACTIONS AT SWEETGRASS NATURAL MEDICINE, THESE ANSWERS ARE CONFIDENTIAL. THANK YOU FOR YOUR TIME, THOUGHTFULNESS AND HONESTY.

WHY DID YOU CHOOSE TO COME TO THIS CLINIC?

WHAT DO YOU KNOW ABOUT OUR APPROACH?

WHAT EXPECTATIONS DO YOU HAVE FROM THIS VISIT TO THIS CLINIC?

WHAT LONG TERM EXPECTATIONS DO YOU HAVE FROM WORKING WITH THIS CLINIC?

WHAT EXPECTATIONS DO YOU HAVE OF ME PERSONALLY AS YOUR PHYSICIAN?

WHAT IS YOUR PRESENT LEVEL OF COMMITMENT TO ADDRESS UNDERLYING CAUSES OF YOUR SIGNS AND SYMPTOMS?

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

WHAT IS YOUR DEFINITION OF HEALTH?

WHAT BEHAVIORS OR LIFESTYLE HABITS DO YOU ENGAGE IN REGULARLY THAT YOU BELIEVE **SUPPORT** YOUR HEALTH?

WHAT BEHAVIORS OR LIFESTYLE HABITS DO YOU ENGAGE IN REGULARLY THAT YOU BELIEVE ARE HARMFUL TO YOUR HEALTH?

WHAT OBSTACLES DO YOU FORESEE IN ADDRESSING LIFESTYLE FACTORS AND IN ADHERING TO THERAPEUTIC PROTOCOLS RECOMMENDED?

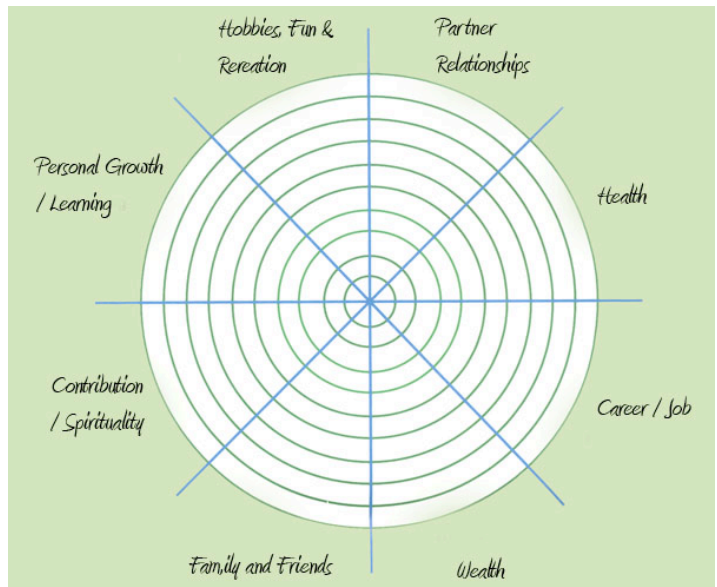
WHAT SUPPORT DO YOU HAVE IN MAKING LIFESTYLE CHANGES?

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 HEALTHCARE?

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) _____

DO YOU HAVE ANY KNOWN INFECTIOUS DISEASE AT THIS TIME? Y N

IF YES, WHAT? _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

- | | | | |
|--------------------|--------------|-------------------|-------------------------|
| ___ CANCER | ___ DIABETES | ___ HEART DISEASE | ___ HIGH BLOOD PRESSURE |
| ___ KIDNEY DISEASE | ___ EPILEPSY | ___ ARTHRITIS | ___ GLAUCOMA |
| ___ TUBERCULOSIS | ___ STROKE | ___ ANEMIA | ___ MENTAL ILLNESS |

___ ASTHMA/HAYFEVER/HIVES ___ ALCOHOLISM

ANY OTHER RELEVANT FAMILY HISTORY? _____

WHAT IS YOUR HERITAGE? _____

CHILDHOOD ILLNESSES

PLEASE CHECK IF YOU HAD AS A CHILD:

___ SCARLET FEVER ___ DIPHTHERIA ___ RHEUMATIC FEVER ___ CHICKEN POX
___ MUMPS ___ MEASLES ___ GERMAN MEASLES ___ RHEUMATIC FEVER

IMMUNIZATIONS

___ POLIO ___ PERTUSSIS ___ MEASLES/MUMPS/RUBELLA
___ TETANUS ___ DIPHTHERIA OTHERS _____

HOSPITALIZATIONS, SURGERY, IMAGING

WHAT HOSPITALIZATIONS, SURGERIES, X-RAYS, CAT SCANS, EEGS, EKGs, COLONOSCOPIES, ULTRASOUNDS, HAVE YOU HAD?

_____ YEAR: _____ _____ YEAR: _____
_____ YEAR: _____ _____ YEAR: _____
_____ YEAR: _____ _____ YEAR: _____

ALLERGIES

ARE YOU HYPERSENSITIVE OR ALLERGIC TO...

ANY DRUGS? _____

ANY FOODS? _____

ANY CHEMICALS OR ENVIRONMENTALS? _____

CURRENT MEDICATIONS

DO YOU TAKE OR USE?

LAXATIVES ___ PAIN RELIEVERS ___ ANTACIDS ___ CORTISONE/STEROIDS ___
APPETITE SUPPRESSANTS ___ ANTIBIOTICS ___ TRANQUILIZERS ___ SLEEP AIDS ___
THYROID MEDS ___ HORMONES ___ BIRTH CONTROL PILL ___ ANTIDEPRESSANTS ___
DIURETICS ___ CHOLESTEROL MEDS ___ OTHER HEART MEDICATION ___ ASTHMA MEDS ___

PLEASE LIST ALL PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS, HERBAL MEDICINES, AND SUPPLEMENTS YOU ARE TAKING.

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

GENERAL

HEIGHT: _____ WEIGHT: _____ LBS. WEIGHT ONE YEAR AGO: _____ LBS.

MAXIMUM WEIGHT: _____ LBS. WHEN: _____ IDEAL WEIGHT: _____ LBS.

WHEN IS YOUR ENERGY THE BEST? _____ WORST? _____

RATE YOUR ENERGY (1-10) _____ IS THIS A CHANGE? _____

HOW IS YOUR MOOD? _____ IS THIS A CHANGE? _____

HOW IS YOUR APPETITE? _____ IS THIS A CHANGE? _____

TYPICAL FOOD INTAKE:

BREAKFAST: _____
 LUNCH: _____
 DINNER: _____
 SNACKS: _____
 CRAVINGS: _____
 DRINKS: _____

HABITS

MAIN INTERESTS AND HOBBIES _____

DO YOU EXERCISE? _____ WHAT KIND _____ ? X PER WEEK? _____

AVERAGE 6-8 HRS 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 TELEVISION?	Y N
HAVE A HISTORY OF ABUSE?	Y N	HOURS PER DAY? _____	
ANY MAJOR TRAUMAS?	Y N P	READ?	Y N
USE RECREATIONAL DRUGS?	Y N P	HOURS PER DAY? _____	
TREATED FOR SUBSTANCE USE?	Y N P	EAT 3 MEALS A DAY?	Y N
DRINK ALCOHOL?	Y N P	GO ON DIETS OFTEN?	Y N
TREATED FOR ALCOHOLISM?	Y N P	EAT OUT OFTEN?	Y N
USE TOBACCO?	Y N P	DRINK COFFEE?	Y N
HOW MANY YEARS? _____		# OF CUPS PER DAY _____	
PACKS PER DAY? _____		DRINK TEA?	Y N
EAT REFINED SUGAR?	Y N	DRINK SODA?	Y N
ADD SALT TO FOODS?	Y N	# OF CANS PER DAY? _____	

DO YOU HAVE A RELIGIOUS OR SPIRITUAL PRACTICE? Y N IF YES, WHAT? _____

REVIEW OF SYSTEMS:

Y=A CONDITION YOU HAVE NOW P = SIGNIFICANT IN THE PAST N = NEVER HAD

MENTAL/EMOTIONAL

TREATED FOR EMOTIONAL PROBLEMS?	Y P N	DEPRESSION?	Y P N
ANXIETY OR NERVOUSNESS?	Y P N	MOOD SWINGS?	Y P N
CONSIDERED/ATTEMPTED SUICIDE?	Y P N	EATING DISORDER?	Y P N
TENSION?	Y P N	POOR CONCENTRATION?	Y P N

ENDOCRINE

THYROID PROBLEMS?	Y P N	HEAT OR COLD INTOLERANCE?	Y P N
HIGH OR LOW BLOOD SUGAR?	Y P N	DIABETES?	Y P N
EXCESSIVE THIRST?	Y P N	EXCESSIVE HUNGER?	Y P N
FATIGUE?	Y P N	SEASONAL DEPRESSION?	Y P N
CRY EASILY?	Y P N	HAIR LOSS?	Y P N

IMMUNE

FREQUENT ILLNESSES?	Y P N	SWOLLEN GLANDS?	Y P N
SLOW WOUND HEALING?	Y P N	AUTOIMMUNE DISEASE?	Y P N
CANCER?	Y P N	WHAT TYPE?	

NEUROLOGIC

SEIZURES?	Y	P	N	DIZZINESS/LIGHTHEADEDNESS?	Y	P	N
LOSS OF BALANCE?	Y	P	N	PARALYSIS?	Y	P	N
NUMBNESS/TINGLING?	Y	P	N	MUSCLE WEAKNESS?	Y	P	N
LOSS OF MEMORY?	Y	P	N	EASILY STRESSED?	Y	P	N

SKIN/HAIR/NAILS

RASHES?	Y	P	N	ECZEMA/HIVES?	Y	P	N
ACNE/BOILS?	Y	P	N	ITCHING?	Y	P	N
DRY/FLAKY SKIN OR BRITTLE NAILS?	Y	P	N	COLOR CHANGES?	Y	P	N
LUMPS?	Y	P	N	NIGHT SWEATS?	Y	P	N

HEAD

HEADACHES?	Y	P	N	MIGRAINES?	Y	P	N
TMJ PROBLEMS?	Y	P	N	HEAD INJURY OR CONCUSSION?	Y	P	N

EYES

BLURRY VISION?	Y	P	N	DOUBLE VISION?	Y	P	N
SPOTS IN THE EYES?	Y	P	N	EYE PAIN/STRAIN?	Y	P	N
COLOR BLINDNESS?	Y	P	N	GLAUCOMA?	Y	P	N
CATARACTS?	Y	P	N	TEARING OR DRYNESS?	Y	P	N

EARS

IMPAIRED HEARING?	Y	P	N	RINGING?	Y	P	N
DIZZINESS?	Y	P	N	EARACHES?	Y	P	N
EAR INFECTIONS?	Y	P	N	CLICKING NOISE ON SWALLOWING?	Y	P	N

NOSE

LOSS OF SMELL?	Y	P	N	STUFFINESS?	Y	P	N
SINUS PROBLEMS?	Y	P	N	FREQUENT COLDS?	Y	P	N
NOSE BLEEDS?	Y	P	N	HAYFEVER?	Y	P	N

MOUTH AND THROAT

FREQUENT SORE THROAT?	Y	P	N	SORE LIPS/TONGUE?	Y	P	N
COPIOUS SALIVA?	Y	P	N	HOARSENESS?	Y	P	N
DENTAL CARIES?	Y	P	N	GUM PROBLEMS?	Y	P	N
TEETH GRINDING?	Y	P	N	JAW CLICKING?	Y	P	N

NECK

LUMPS?	Y	P	N	GOITER?	Y	P	N
SWOLLEN GLANDS?	Y	P	N	STIFF/PAINFUL NECK?	Y	P	N

CARDIOVASCULAR

HEART DISEASE?	Y	P	N	ANGINA?	Y	P	N
CHEST PAIN?	Y	P	N	PALPITATIONS/FLUTTERS?	Y	P	N
MURMUR?	Y	P	N	SWELLING OF ANKLES?	Y	P	N
BLOOD CLOTS?	Y	P	N	PHLEBITIS (PROBLEM WITH VEINS)?	Y	P	N
HEART ATTACK OR STROKE?	Y	P	N	HIGH/LOW BLOOD PRESSURE?	Y	P	N
FAINING?	Y	P	N	RHEUMATIC FEVER?	Y	P	N

RESPIRATORY

COUGH?	Y	P	N	SPUTUM?	Y	P	N
SPITTING UP BLOOD?	Y	P	N	WHEEZING?	Y	P	N
ASTHMA?	Y	P	N	EMPHYSEMA?	Y	P	N
PNEUMONIA?	Y	P	N	BRONCHITIS?	Y	P	N
PLEURISY?	Y	P	N	TUBERCULOSIS?	Y	P	N
PAIN ON BREATHING?	Y	P	N	DIFFICULTY BREATHING?	Y	P	N
SHORTNESS OF BREATH?	Y	P	N	SHORT OF BREATH LYING DOWN?	Y	P	N
LIGHTHEADED WITH EXERTION?	Y	P	N	SHALLOW BREATHING?	Y	P	N

GASTROINTESTINAL

DIFFICULTY SWALLOWING?	Y	P	N	HEARTBURN?	Y	P	N
CHANGE IN THIRST?	Y	P	N	CHANGE IN APPETITE?	Y	P	N
ULCER?	Y	P	N	NAUSEA?	Y	P	N
VOMITING?	Y	P	N	VOMITING BLOOD?	Y	P	N
BELCHING OR GAS?	Y	P	N	PAIN OR CRAMPS?	Y	P	N
BOWEL MOVEMENTS: HOW OFTEN _____ IS THIS A CHANGE? Y N				DIARRHEA?	Y	P	N
CONSTIPATION?	Y	P	N	BLOOD IN STOOL?	Y	P	N
BLACK STOOL?	Y	P	N	HEMMORHOIDS?	Y	P	N
LIVER DISEASE?	Y	P	N	GALLBLADDER DISEASE?	Y	P	N

URINARY

PAIN ON URINATION?	Y	P	N	INCREASED FREQUENCY?	Y	P	N
FREQUENCY AT NIGHT?	Y	P	N	INABILITY TO HOLD URINE?	Y	P	N
FREQUENT URINARY TRACT INFECTIONS?	Y	P	N	KIDNEY STONES?	Y	P	N
KIDNEY DISEASE?	Y	P	N	ABNORMAL COLOR OR SMELL OF URINE?	Y	P	N

MALE REPRODUCTIVE

HERNIAS?	Y	P	N	TESTICULAR MASSES?	Y	P	N
TESTICULAR PAIN?	Y	P	N	PROSTATE DISEASE?	Y	P	N
VENEREAL DISEASE?	Y	P	N	DISCHARGE OR SORES?	Y	P	N
GENITAL WARTS?	Y	P	N	CHLAMYDIA?	Y	P	N
SYPHILIS?	Y	P	N	HERPES?	Y	P	N
SEXUALLY ACTIVE?	Y	P	N	IMPOTENCE?	Y	P	N
LOW SEX DRIVE?	Y	P	N	PREMATURE EJACULATION?	Y	P	N
FERTILITY DIFFICULTIES?	Y	P	N	BIRTH CONTROL? Y N TYPE?			

FEMALE REPRODUCTIVE/BREASTS

AGE OF FIRST MENSES?				AGE OF LAST MENSES?			
IS YOUR CYCLE REGULAR?	Y	P	N	DURATION OF CYCLE (#DAYS)?			
DURATION BETWEEN CYCLES (# DAYS)?				BLEEDING BETWEEN CYCLES?	Y	P	N
PAIN/CRAMPING DURING MENSES?	Y	P	N	HEAVY OR EXCESSIVE FLOW?	Y	P	N
CLOTTING?	Y	P	N	OVARIAN CYSTS?	Y	P	N
FIBROIDS?	Y	P	N	ENDOMETRIOSIS?	Y	P	N
ABNORMAL PAP?	Y	P	N	CERVICAL DYSPLASIA?	Y	P	N
SEXUALLY ACTIVE?	Y	P	N	SEXUAL ORIENTATION?	Y	P	N
BIRTH CONTROL METHOD?				DIFFICULTY CONCEIVING?	Y	P	N
#OF PREGNANCIES				#OF MISCARRIAGES			
#OF LIVE BIRTHS				#OF ABORTIONS			
GENITAL WARTS?	Y	P	N	CHLAMYDIA?	Y	P	N
SYPHILIS?	Y	P	N	HERPES?	Y	P	N
VAGINAL DISCHARGE?	Y	P	N	VAGINAL ITCHING?	Y	P	N
VAGINAL PAIN?	Y	P	N	INTERSTITIAL CYSTITIS?	Y	P	N
DO YOU PERFORM SELF BREAST EXAMS?	Y		N	BREAST LUMPS?	Y	P	N
BREAST PAIN OR TENDERNESS?	Y	P	N	NIPPLE DISCHARGE?	Y	P	N

MUSCULOSKELETAL

JOINT PAIN OR STIFFNESS?	Y	P	N	BROKEN BONES?	Y	P	N
ARTHRITIS?	Y	P	N	MUSCLE WEAKNESS?	Y	P	N
MUSCLE CRAMPS?	Y	P	N	SCIATICA?	Y	P	N

BLOOD/PERIPHERAL VASCULAR

DEEP LEG PAIN?	Y	P	N	VARICOSE VEINS?	Y	P	N
THROMBOPHLEBITIS?	Y	P	N	COLD HANDS OR FEET?	Y	P	N
EASY BLEEDING?	Y	P	N	EASY BRUISING?	Y	P	N
ANEMIA?	Y	P	N	SWELLING?	Y	P	N

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR HEALTH? _____

SIGNATURE: _____ DATE: _____

Thank you for taking time to help me better understand your whole health. I look forward to working with you. If you have any questions please ask!

Dr. Holcomb Johnston