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WWW.SWEETGRASSMEDICINE.COM

**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.#: \_\_\_\_\_  
(WORK ADDRESS): \_\_\_\_\_  
WHO MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? \_\_\_\_\_  
HAS ANY OTHER FAMILY MEMBER ALREADY BEEN A PATIENT AT THE CLINIC? \_\_\_\_\_

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?

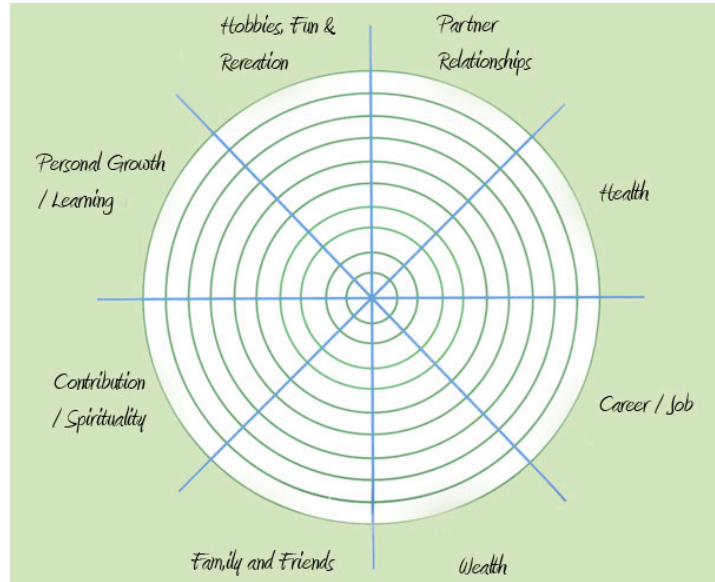
WHAT SUPPORT DO YOU HAVE IN MAKING LIFESTYLE CHANGES?

**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
FAINTING?	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*