



**JUSTIN MORSE ND**  
ABSOLUTE HEALTH INC.  
1165 PEARL ST. EUGENE OR 97401  
541-343-4343

## Health Intake Form

Name \_\_\_\_\_ Date of First Visit \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # (home) \_\_\_\_\_ (work) \_\_\_\_\_

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) \_\_\_\_\_

Health insurance co. name and address \_\_\_\_\_

Telephone number (\_\_\_\_) \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Policy holder's name \_\_\_\_\_ Employer \_\_\_\_\_

Identification/Social Security # \_\_\_\_\_

How did you hear about 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 \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_



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*PLEASE FILL OUT BOTH SIDES OF EACH PAGE*

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

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 problems? List as many as you can in order of importance.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_

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

If yes, what? \_\_\_\_\_

**FAMILY HISTORY**

|  | <u>FATHER</u> | <u>MOTHER</u> | <u>BROTHERS</u> | <u>SISTERS</u> | <u>SPOUSE</u> | <u>CHILD</u> |
|--|---------------|---------------|-----------------|----------------|---------------|--------------|
| Age (if living)                          | _____         | _____         | _____           | _____          | _____         | _____        |
| Health (G=good P=poor)                   | _____         | _____         | _____           | _____          | _____         | _____        |
| Age at death (if deceased)               | _____         | _____         | _____           | _____          | _____         | _____        |
| <b><u>Check (√) those applicable</u></b> |               |               |                 |                |               |              |
| Cancer                                   | _____         | _____         | _____           | _____          | _____         | _____        |
| Diabetes                                 | _____         | _____         | _____           | _____          | _____         | _____        |
| Heart Disease                            | _____         | _____         | _____           | _____          | _____         | _____        |
| High Blood Pressure                      | _____         | _____         | _____           | _____          | _____         | _____        |
| Stroke                                   | _____         | _____         | _____           | _____          | _____         | _____        |
| Epilepsy                                 | _____         | _____         | _____           | _____          | _____         | _____        |
| Mental Illness                           | _____         | _____         | _____           | _____          | _____         | _____        |



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|                       | <u>FATHER</u> | <u>MOTHER</u> | <u>BROTHERS</u> | <u>SISTERS</u> | <u>SPOUSE</u> | <u>CHILD</u> |
|-----------------------|---------------|---------------|-----------------|----------------|---------------|--------------|
| Asthma/Hayfever/Hives | _____         | _____         | _____           | _____          | _____         | _____        |
| Anemia                | _____         | _____         | _____           | _____          | _____         | _____        |
| Kidney Disease        | _____         | _____         | _____           | _____          | _____         | _____        |
| Glaucoma              | _____         | _____         | _____           | _____          | _____         | _____        |
| Tuberculosis          | _____         | _____         | _____           | _____          | _____         | _____        |
| Cause of Death        | _____         | _____         | _____           | _____          | _____         | _____        |

**Allergies**

Are you hypersensitive or allergic to...

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

**For all the following sections,**

**Y** = a condition you have now    **N** = never had    **P** = a condition you have had before

**Childhood Illnesses**

|               |       |            |       |                 |       |
|---------------|-------|------------|-------|-----------------|-------|
| Scarlet fever | Y N P | Diphtheria | Y N P | Rheumatic fever | Y N P |
| Mumps         | Y N P | Measles    | Y N P | German measles  | Y N P |

**Hospitalization and Surgery**

What hospitalizations or surgeries have you had?

\_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_  
 \_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_

**X-Rays and Special Studies**

X-rays, CAT scans, or other studies you have had:

|                   |       |                      |       |
|-------------------|-------|----------------------|-------|
| _____             | _____ | _____                | _____ |
| Electrocardiogram | Y N   | Electroencephalogram | Y N   |

**Immunizations**

|                       |     |             |     |
|-----------------------|-----|-------------|-----|
| Polio                 | Y N | Pertussis   | Y N |
| Tetanus shot          | Y N | Diphtheria  | Y N |
| Measles/Mumps/Rubella | Y N | Other _____ |     |

**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 |

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Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking. Please list dose as well.

- 1) \_\_\_\_\_ 4) \_\_\_\_\_  
2) \_\_\_\_\_ 5) \_\_\_\_\_  
3) \_\_\_\_\_ 6) \_\_\_\_\_

**Typical Food Intake**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

**HABITS**

Main interests and hobbies? \_\_\_\_\_

Do you exercise? Y N

If yes, what kind? \_\_\_\_\_ How often? \_\_\_\_\_

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 how many hours? \_\_\_\_\_

Any major traumas? Y P N Read? Y N

Use recreational drugs? Y P N how many hours? \_\_\_\_\_

Been treated for drug dependence? Y P N

Do you eat three meals a day? Y N Use alcoholic beverages? Y P N

Do you eat out often? Y N Treated for alcoholism? Y P N

Do you go on diets often? Y N Do you use tobacco? Y P N

Do you drink coffee? Y P N Smoked previously? Y P N

Do you drink black or green tea? Y P N how many years? \_\_\_\_\_

Do you drink cola or other sodas? Y P N how many packs per day? \_\_\_\_\_

Do you eat refined sugar? Y P N

Do you add salt? Y P N

Do you have a religious or spiritual practice? Y N If yes, what? \_\_\_\_\_

How does your condition affect you? \_\_\_\_\_

\_\_\_\_\_

What do you think is happening? \_\_\_\_\_

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\_\_\_\_\_  
 \_\_\_\_\_

Why? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

What do you feel needs to happen for you to get better? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

What do you enjoy most in your life? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**How much change are you willing to make at this time for improving your health?**

MINIMAL SOME COMPLETE

Is there any information about your health you would like to add? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**GENERAL**

Weight \_\_\_\_\_ lbs. Weight 1 year ago \_\_\_\_\_ lbs.  
 Maximum Weight \_\_\_\_\_ When \_\_\_\_\_  
 Height \_\_\_\_\_  
 When during the day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_

**REVIEW OF SYSTEMS**

**FOR THE FOLLOWING, PLEASE CIRCLE**

Y = a condition you have now N = never had P = a condition you have had before

**MENTAL/ EMOTIONAL**

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

**ENDOCRINE**

|                   |       |                           |       |
|-------------------|-------|---------------------------|-------|
| Hypothyroid?      | Y P N | Heat or cold intolerance? | Y P N |
| Hypoglycemia?     | 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 |

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**IMMUNE**

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

**NEUROLOGIC**

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

**SKIN**

|               |       |                      |       |
|---------------|-------|----------------------|-------|
| Rashes?       | Y P N | Eczema, Hives?       | Y P N |
| Acne, Boils?  | Y P N | Itching?             | Y P N |
| Color Change? | Y P N | Perpetual Hair Loss? | Y P N |
| Lumps?        | Y P N | Night Sweats?        | Y P N |

**HEAD**

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

**EYES**

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

**EARS**

|                   |       |            |       |
|-------------------|-------|------------|-------|
| Impaired hearing? | Y P N | ringing?   | Y P N |
| Earaches?         | Y P N | Dizziness? | Y P N |

**NOSE AND SINUSES**

|                 |       |                |       |
|-----------------|-------|----------------|-------|
| Frequent colds? | Y P N | Nose Bleeds?   | Y P N |
| Stiffness?      | Y P N | Hayfever?      | Y P N |
| Sinus problems? | Y P N | Loss of smell? | Y P N |

**MOUTH AND THROAT**

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

**NECK**

|         |       |                    |       |
|---------|-------|--------------------|-------|
| Lumps?  | Y P N | Swollen glands?    | Y P N |
| Goiter? | Y P N | Pain or stiffness? | 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 | Bronchitis? | Y P N |

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|                               |       |                       |       |
|-------------------------------|-------|-----------------------|-------|
| Pneumonia?                    | Y P N | Pleurisy?             | Y P N |
| Emphysema?                    | Y P N | Difficulty breathing? | Y P N |
| Pain on breathing?            | Y P N | Shortness of breath?  | Y P N |
| Shortness of breath at night? | Y P N | " " " " "lying down?" | Y P N |
| Tuberculosis?                 | Y P N |                       |       |

**CARDIOVASCULAR**

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

**GASTROINTESTINAL**

|                          |       |                                   |       |
|--------------------------|-------|-----------------------------------|-------|
| Trouble swallowing?      | Y P N | Heartburn?                        | Y P N |
| Change in thirst?        | Y P N | Change in appetite?               | Y P N |
| Nausea?                  | Y P N | Vomiting?                         | Y P N |
| Vomiting blood?          | Y P N | Bowel Movements: How often? _____ |       |
| Blood in stool?          | Y P N | Is this a change? _____           |       |
| Pain or cramps?          | Y P N | Constipation?                     | Y P N |
| Belching or passing gas? | Y P N | Diarrhea?                         | Y P N |
| Black stools?            | Y P N | Gall Bladder disease?             | Y P N |
| Jaundice (yellow skin)?  | Y P N | Ulcer?                            | Y P N |
| Liver Disease?           | Y P N | Hemorrhoids?                      | 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 infections? | Y P N | Kidney stones?           | Y P N |

**MALE REPRODUCTION**

|                            |       |                     |       |
|----------------------------|-------|---------------------|-------|
| 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 |
| Are you sexually active?   | Y N   | Chlamydia?          | Y P N |
| Sexual orientation: _____  |       | Gonorrhea?          | Y P N |
| Impotence?                 | Y P N | Condyloma?          | Y P N |
| Premature ejaculation?     | Y P N | Herpes?             | Y P N |
| Birth control? Type? _____ |       | Syphilis?           | Y P N |

**FEMALE REPRODUCTION/BREASTS**

|                                |       |                          |       |
|--------------------------------|-------|--------------------------|-------|
| Age of first menses? _____     |       | Are cycles regular?      | Y N   |
| Age of last mense? _____       |       | Bleeding between cycles? | Y P N |
| Length of cycle? _____ days    |       | Pain during intercourse? | Y P N |
| Duration of menses? _____ days |       | Clotting?                | Y P N |
| Painful menses?                | Y P N | Discharge?               | Y P N |
| Heavy or excessive flow?       | Y P N |                          |       |

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|                                 |       |                              |       |
|---------------------------------|-------|------------------------------|-------|
| PMS?                            | Y P N | Birth control?               | Y P N |
| If yes, what are your symptoms? |       | What type? _____             |       |
| _____                           |       | Number of pregnancies _____  |       |
| _____                           |       | Number of live births _____  |       |
| Endometriosis?                  | Y P N | Number of miscarriages _____ |       |
| Ovarian cysts?                  | Y P N | Number of abortions _____    |       |
| Difficulty conceiving?          | Y P N | Menopausal symptoms?         | Y P N |
| Cervical Dysplasia?             | Y P N | Abnormal PAP?                | Y P N |
| Sexual difficulties?            | Y P N | Chlamydia?                   | Y P N |
| Gonorrhea?                      | Y P N | Condyloma?                   | Y P N |
| Herpes?                         | Y P N | Syphilis?                    | Y P N |
| Are you sexually active?        | Y N   | Sexual orientation: _____    |       |
| Do you do breast self exams?    | Y P N | Breast lumps?                | Y P N |
| Breast pain/tenderness?         | Y P N | Nipple discharge?            | Y P N |

**MUSCULOSKELETAL**

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

**BLOOD/PERIPHERAL VASCULAR**

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

*Welcome! We're glad to serve you! If you have any questions, please ask!*