# Dr. Emily Kane

**Doctor of Naturopathic Medicine AK License #22**
**Licensed Acupuncturist AK License #18**

Name: _____ Age: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Sex: F M
Emergency Contact: _____ Phone: _____

**INSURANCE INFORMATION** (if applicable):

Name of insured: _____ Insured ID: _____
Employer: _____
Insurance Company: _____ Group #: _____

Please list, in order of importance, your most important health problems:

1): _____
2): _____
3): _____
4): _____
5): _____

**YOUR HEALTH HISTORY** (Please circle relevant areas):

| | | |
|---|---|---|
| Alcoholism | Diabetes | Liver disorders |
| Allergies | Gout | Psychological disorders |
| Anemia | Heart disorders | Skin disorders |
| Arthritis | Herpes genitalis | Stroke |
| Asthma | Hypertension | Thyroid disorders |
| Cancer | Hypoglycemia | Tuberculosis |
| Colitis | Injury (serious) | Venereal disease |

Other:

_____
_____
_____

**HOSPITALIZATIONS** (including dates and type of illness/operation):

_____
_____
_____

**Known ALLERGIES** (to medications, foods, pollens, etc.):

_____
_____
_____

**Current MEDICATIONS and SUPPLEMENTS** (include prescription and non-prescription items, herbs, vitamins, minerals, etc): _____

_____

_____

**DIET and HEALTH HABITS**:

Number of meals per day: _____
List foods excluded from your diet: _____
Past 24 hour food intake:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

How many glasses of plain water do you drink per day? _____
List 5 foods most frequently eaten: _____

YES NO Satisfied with your diet as it is now?
YES NO Drink alcohol? If yes, amount per week: _____
YES NO Drink coffee or soft drinks? If yes, how much? _____
YES NO Smoke cigarettes? If yes, how many per day? _____

Exercise routine (describe type and frequency): _____

_____

_____

**FAMILY HISTORY** (circle if yes):

| | | |
|---|---|---|
| Alcoholism | Gout | Seizures |
| Allergies | Hay Fever | Sickle cell anemia |
| Anemia | Heart disease | Skin disorders |
| Asthma | High blood pressure | Stroke |
| Cancer | Hepatitis | Thyroid disorders |
| Diabetes | Hypoglycemia | Tuberculosis |
| Glaucoma | Mental illness | Venereal disease |

Other significant family health problems:

_____

_____

_____

**WOMEN ONLY**:

| | | |
|---|---|---|
| Pregnancies: _____ | Births: _____ | Miscarriage/Abortion: _____ |
| Age at first menses: _____ | Cycles regular? _____ | Length of cycle: _____ |
| Duration of menses: _____ | Date of last menses: _____ | Date of last PAP: _____ |
| Breast Lumps? _____ | Do you practice birth control? | YES NO |

If yes to birth control, what type and for how long? _____

_____

Please wear your seatbelt. Thank you!

**DR'S NOTES**:

appetite fever/chills sweat fatigue weakness sleep cravings weight sensory
Skin/Hair HEENT Cardiac Resp GI GU MuscSkel NeuroPsych Trauma Hx