The Oasis Institute

PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY

ALL QUESTIONS ARE OPTIONAL: SKIP QUESTIONS THAT DO NOT APPLY TO YOU

NAME: ____

Date: ____________________________ EMAIL: ____________________________

Sex: Male/female DOB: ______________________________________

PRIMARY CARE PROVIDER: ________________________ Phone# ______________

HOME ADDRESS: ____

PHONE HOME: ______________ WORK: _______________ CELL:______________

Please describe your goals and expectations regarding your appointment at the Oasis Institute:-

If you are experiencing pain now or having on-going pain please fill out the following section:-

Location: ____

Quality: ____

Radiation: ____

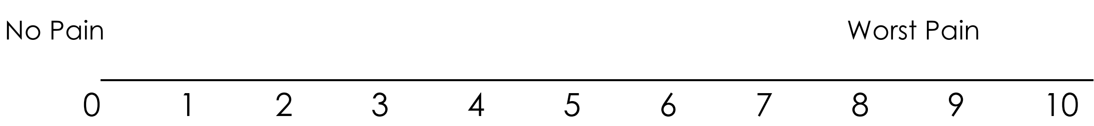
What makes it better? _____________________________________

What makes it worse? ______________________________________

How long have you had it? _________________________________

Mark an X on the line where your pain is currently:-

No Pain   Worst Pain



0 1 2 3 4 5 6 7 8 9 10

Please describe how your pain affects your daily activities:-

____

____

____

Please describe any accidents you have had (include dates and injuries)

____

____

____

Medical conditions/Illness/Past Medical History

Menstrual History, including last cycle:

Psychiatric Hospitalizations:

Surgeries (dates and procedures):

Current Medications (not herb or supplements):

Please list any **natural health products** used (herbs, supplements, vitamins, special foods):

Product:__________________ Brand: ________________ Dose:_____________ Frequency:______

Product:__________________ Brand: ________________ Dose:_____________ Frequency:______

Product:__________________ Brand: ________________ Dose:_____________ Frequency:______

Product:__________________ Brand: ________________ Dose:_____________ Frequency:______

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Product:__________________ Brand: ________________ Dose:_____________ Frequency:______

Product:__________________ Brand: ________________ Dose:_____________ Frequency:______

Product:__________________ Brand: ________________ Dose:_____________ Frequency:______

Allergies/intolerances to medication or substances:

____

____

____

____

Current/recent medical and other health care providers:
(Name of Practitioner & type of Practitioner such as Physical Therapy, Psychology, Acupuncturist)

____

____

____

Please list ALL Complementary and Alternative therapies or Practitioners you have seen:

___

___

___

Please list year of most recent:

Colonoscopy ___________________

Stool Test _______________________

Flu Shot _________________________

PAP Smear ______________________

Bone Density __________________

BMI ___________________________

Mammogram _________________

Prostate Exam _________________

How would you describe your health (circle one) Poor Average Good

Family history of health problems or conditions: (parents, siblings, children, grandparents)

___

___

___

Social History:

How many sexual partners have you had in the last year? ______________________

Describe the current state of your finances: ____________________________________

____

Education Level: _____________________________________

Occupation: ____

Please describe your religion / spirituality:

___

___

___

___

___

Hobbies:___

Housemates/living situation: ___

If you presently follow any regular exercise program, please list what, when you started, and how many times weekly:

___

___

___

Please list the types of volunteer work and hobbies that currently do and have done in the past:-

Volunteer/Hobby	**Year**

List the things that cause you the most stress in your life now:- (e.g. relationships, family, health, money, job, etc.) and number them in order of significance

________________________________ __________

________________________________ __________

________________________________ __________

________________________________ __________

________________________________ __________

________________________________ __________

How would you rate your stress level in the past month?

Mark an X on the line where your stress is currently:-

No Stress Stressed Out

0 1 2 3 4 5 6 7 8 9 10

How would you rate your emotional state in the past month?

Mark an X on the line in the appropriate area:-

Sad Happy

0 1 2 3 4 5 6 7 8 9 10

Would you consider yourself to be more of an optimist or pessimist?

Mark an X on the line in the appropriate area:- :-

Pessimist Optimist

0 1 2 3 4 5 6 7 8 9 10

What do you do for relaxation / coping?

Mark and X on the line for your energy level at various times of the day:-

Morning

Low High

0 1 2 3 4 5 6 7 8 9 10

Afternoon

Low High

0 1 2 3 4 5 6 7 8 9 10

Evening

Low High

0 1 2 3 4 5 6 7 8 9 10

Please describe how fatigue or low energy affects your daily activities:-

Describe your sleep:

Describe how sleep deprivation affects your daily activities:-

____

____

____

Diet and Nutrition History:-

Coffee? _______ How much per day? ____________

Soda ? _______ How much per day ? ___________

Do you now or have ever used Tobacco? How much per week?____________

Do you now or have ever used Alcohol? How much per week?____________

Do you now or have ever used Marijuana? How much per week?____________

Do you now or have ever used other drugs (Non-prescriptive)? How much per week and what drugs

____

____

Recall of Dietary intake:

Please list all foods and drinks you have consumed in the previous 24 Hours. Include meals, snacks, beverages and condiments.

Breakfast: ____

____

Lunch: ____

Dinner ____

____

Snacks: ____

____

Is this a typical day? If not why not, please describe

____

____

Are there any types or Groups of foods you dislike or rarely eat?

____

____

What do you drink on a typical day:

____

____

What type of oil do you cook with? ____

What type of spreads do you add to your foods? ________________________________

How many cups (8oz) of water do you drink in a typical day? ____________________

How many servings of fruit do you eat on a typical day?
(1 serving = 1 small piece – cup of juice- cup of canned or chopped or cup of dried)

____

How many servings of Vegetables do you eat on a typical day?
(1 serving = 1 small piece – cup of juice- cup leafy greens or raw or cooked or dried)

____

Please describe your Relationship to food:-

Highest Weight: ___________________________ Desired weight: _______________________

Please described your mood:-

Please describe your childhood:_

How would you rate your own health as a child:- Good Fair Poor

List any traumas (emotional, verbal, physical and sexual) you have experienced:-

Current Symptoms:- circle if problematic and explain if necessary:-

Allergies ____

Arthritis ____

Asthma ____

Bitter taste in mouth ____

Blurry Vision ____

Breathing Problems ____

Brittle Nails ____

Bruising ____

Bursitis (where) ____

Cancer/Tumor ____

Chest Pains / Tightness ____

Cough ____

Diabetes ____

Difficulty concentrating ____

Digestive Problems ____

Ear ringing ____

Easily Angered ____

Emphysema ____

Fatigue ____

Frequent Colds/Flu's ____

Hearing Problems ____

Heart conditions / type ____

Hemorrhoids ____

High Blood Pressure ____

Hot Flashes ____

Infections (where?) ____

Inflammation (where?) ____

Irregular heartbeat ____

Low blood pressure ____

Nightmares ____

Night Sweats ____

Numbness / tingling (where) ____

Menstrual / Gynecological symptoms ___________________________________

Poor Appetite ____

Poor Memory ____

Rapid Heartbeat ____

Red dry eyes ____

Sciatica ____

Seizures / Convulsions ____

Shortness of breath ____

Skin conditions / rash (where) ____

Stroke ____

Trouble Sleeping ____

Urinary problems ____

Varicose Veins ____

Weak Immune System (describe) _______________________________________

Is there any other information you would like to share with us?

____

____

____

Thank you for taking the time to complete this extensive form. This information will be very helpful in your evaluation and assessment

We look forward to your visit and working with you to meet your goals!

Health is not just the absence of disease