Mark Davis, ND | Emily Burke, ND
827 NE Alberta Street Portland, Oregon 97211
tel 503.928.7605 fax 971.239.1913
info@brightmedicineclinic.com
www.brightmedicineclinic.com

I am a: ☐ New Patient ☐ Consultee

And I have an appointment with: ☐ Dr. Mark Davis ☐ Dr. Emily Burke

Demographic Information

Date:_____ Name:_____ Age:_____

Birthday:____/____/____ Social Security#:_____-_____-_____ ☐M ☐F Home Phone:_____

Address:_____ Cell Phone:_____

City:_____ State:_____ Zip:_____

Are you: ☐Single ☐Married ☐Significant Partner Living with: ☐Spouse /Partner ☐Parents ☐Children ☐Relatives ☐Friends ☐Alone

Occupation:_____ Employer:_____ Work Phone:_____

Email:_____ I

May we leave a medically related message at home? _____ on cell? _____ via email? _____

Emergency Contact:_____ Relationship:_____ Phone_____

Who can we thank for referring you? _____

Notice of Privacy Practices

My signature below acknowledges that I have had the opportunity to review the privacy practices in place at Bright Medicine Clinic regarding my protected health information.

_____ _____ _____
Patient Signature or Guardian if patient is under 18 years of age | Relationship to patient | Date

Consent Form & Agreement for Patients

Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications of the specific treatments or procedures you may undergo is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

My signature below signifies that I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

_____ _____ _____
Patient Signature or Guardian if patient is under 18 years of age | Relationship to patient | Date

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Health History Questionnaire

Holistic health care and preventive medicine are only possible when the physician has a complete understanding of your physical, mental, emotional and spiritual nature. Therefore, please take the time to carefully and thoroughly complete your questionnaire. Complete all information and mark anything you don't understand with a question mark.

Where did you last receive health care? _____ When? _____

Reason for last visit: _____

Please list your most important health concerns and when they started:

1. _____
2. _____
3. _____
4. _____

What are your current diagnoses:

_____

_____

_____

Allergies (Please list any drugs, foods, or substances and your reaction):

_____

_____

Do you routinely take?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Hormones	Y	N	Thyroid medication	Y	N
Tranquilizers	Y	N	Sleeping pills	Y	N	Antidepressants	Y	N

Please list (or submit a copy of your list) of all prescription medications, over the counter medications, vitamins or other supplements you are currently taking, include dosages and reasons for taking them: _____

_____

_____

_____

Exposure Are you aware or do you suspect that you have been exposed to toxic substances in your home or work environment?

Please describe _____

_____

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Childhood illnesses:

Rheumatic fever	Y	N	Measles- 2 week	Y	N	German measles-3 day	Y	N
Chicken pox	Y	N	Eczema	Y	N	Asthma	Y	N
Ear infections?	Y	N	Do you have your tonsils?	Y	N	Other _____		

Immunizations:

Diphtheria	Y	N	Tetanus (within past 10 yrs)	Y	N	Measles/Mumps/Rubella	Y	N
Pertussis	Y	N	Last PPD_____			Other_____		

FAMILY HISTORY:

Check those applicable	Father	Mother	Brother	Sister	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health: G=good P=poor	_____	_____	_____	_____	_____	_____
Cancer (type?)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart attack or heart failure	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____	_____
Asthma, hay fever, hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Rheumatoid arthritis	_____	_____	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____	_____	_____
Age deceased	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

Hospitalizations and Surgeries (list reason &/or type of surgery and date):

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Most recent blood work (type & date) _____

Last bone densitometry _____

Last physical _____ Last EKG _____

Last dental exam/cleaning _____ Last eye exam _____

Last chest x-ray _____ Last spinal x-ray _____

Women

Last Pap smear & result _____ Last mammogram _____

Men

Last testicular/prostate exam _____

***Please circle: Y*= a condition/circumstance you have now *N*= never had condition**

***P*= Past condition/circumstance**

General:

Weight _____			
Weight 1 yr ago _____	Y	N	P
Satisfied with weight?	Y	N	
Height _____	Y	N	P
Fatigue _____	Y	N	P
Night sweats	Y	N	P
Do you sleep well	Y	N	P
Awaken rested	Y	N	P
Average 6-8 hrs sleep	Y	N	P
Work unusual hours	Y	N	P
Enjoy your work	Y	N	P
Take vacations	Y	N	P
Spend time outdoors	Y	N	P
Exercise routinely	Y	N	P
What forms? _____			

General cont.:

How often _____			
Use tobacco, how much _____	Y	N	P
Drink alcohol, how much _____	Y	N	P
Treated for alcoholism	Y	N	P
Use recreational drugs	Y	N	P
Treated for drug abuse	Y	N	P

Skin:

Rashes	Y	N	P
Eczema, hives	Y	N	P
Acne, boils	Y	N	P
Itching	Y	N	P
Color change	Y	N	P
Lumps	Y	N	P
Herpes	Y	N	P

Head:

Tension headaches	Y	N	P
Migraines	Y	N	P
Hair loss	Y	N	P
Head injury	Y	N	P

Eyes:

Change in vision	Y	N	P
Double vision	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P
Eye pain	Y	N	P
Tearing or dryness	Y	N	P
Glasses or contacts	Y	N	P

Ears:

Hard of hearing	Y	N	P
Ringing	Y	N	P

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Dizziness	Y	N	P
Earache	Y	N	P

Nose/sinuses:

Frequent colds	Y	N	P
Stuffiness	Y	N	P
Sinus infections	Y	N	P
Hay fever	Y	N	P
Frequent nose bleeds	Y	N	P

Mouth & throat:

Frequent sore throat	Y	N	P
Sore/swollen tongue	Y	N	P
Difficulty swallowing	Y	N	P
Hoarseness	Y	N	P
Frequently clear throat	Y	N	P
Bleeding/receding gums	Y	N	P
Dental cavities	Y	N	P
Toothache/sensitivities	Y	N	P

Neck:

Lumps	Y	N	P
Swollen glands	Y	N	P
Goiter	Y	N	P
Pain or stiffness	Y	N	P

Respiratory:

Asthma	Y	N	P
Emphysema	Y	N	P
Frequent cough	Y	N	P
Productive cough	Y	N	P
Bronchitis	Y	N	P
Shortness of breathe	Y	N	P
Wheezing at night	Y	N	P
Wheezing lying down	Y	N	P
Wheezing on exertion	Y	N	P
Pain on breathing	Y	N	P
Pneumonia	Y	N	P
Pleurisy	Y	N	P
Tuberculosis	Y	N	P

Cardiovascular:

Heart failure	Y	N	P
Heart attack	Y	N	P
Chest pain/angina	Y	N	P
High blood pressure	Y	N	P
High cholesterol	Y	N	P
Fluttering in chest	Y	N	P
Heart murmur	Y	N	P
Rheumatic fever	Y	N	P
Swelling in ankles	Y	N	P

Gastrointestinal:

Frequent indigestion	Y	N	P
Vomiting	Y	N	P
Vomiting blood	Y	N	P
Blood in stool	Y	N	P
Abdominal pain	Y	N	P
Gallbladder pain	Y	N	P
Liver disease/hepatitis	Y	N	P
Frequent belching/gas	Y	N	P
Heartburn	Y	N	P
Ulcers	Y	N	P
Hemorrhoids	Y	N	P
Constipation	Y	N	P
Diarrhea	Y	N	P

Bowel movements How often? _____
Is this a change? _____

Urinary:

Pain on urination	Y	N	P
Increased frequency	Y	N	P
Frequency at night	Y	N	P
Dribble urine	Y	N	P
Frequent infections	Y	N	P
Kidney stones	Y	N	P

Breasts:

Do you do self-exam?	Y	N	P
Lumps	Y	N	P
Pain or tenderness	Y	N	P
Nipple discharge	Y	N	P

Female reproductive:

Ave. # of days of cycle ____ Length of cycles _____

Regular cycles	Y	N	P
Skipped cycle(s)	Y	N	P
Breakthrough bleeding	Y	N	P
Menopausal symptoms	Y	N	P
Sexually active	Y	N	P
Pain with intercourse	Y	N	P
Birth control? What type _____	Y	N	P

# of pregnancies _____ # of live births _____
# of miscarriages _____ # of abortions _____

Difficulty conceiving	Y	N	P
Sexually transmitted disease	Y	N	P

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Sexual difficulties	Y	N	P
Freq. vaginal infections	Y	N	P

Male reproductive:			
Hernias	Y	N	P
Testicular lump	Y	N	P
Testicular pain	Y	N	P
Prostate disease	Y	N	P
Sexually active	Y	N	P
Birth control? What type_____	Y	N	P
Sexually difficulties	Y	N	P
Difficulty conceiving	Y	N	P
Sexually transmitted disease	Y	N	P

Musculoskeletal:

Joint pain/stiffness	Y	N	P
Arthritis	Y	N	P
Broken bones	Y	N	P
Osteoporosis	Y	N	P
Muscle spasms/cramps	Y	N	P
Muscle weakness	Y	N	P
Loss of coordination	Y	N	P

Peripheral vascular:

Blood clots	Y	N	P
Anemia	Y	N	P
Easy bleeding/bruising	Y	N	P
Varicose veins	Y	N	P
Cold hands/feet	Y	N	P
Raynauds disease	Y	N	P

Neurologic:

Head injury	Y	N	P
Stroke	Y	N	P
Seizures	Y	N	P
Fainting	Y	N	P
Paralysis	Y	N	P
Numbness or tingling	Y	N	P
Memory loss	Y	N	P
Loss taste or smell	Y	N	P
Loss of balance	Y	N	P

Endocrine:

Hyperthyroid	Y	N	P
Hypothyroid	Y	N	P
Heat/cold intolerance	Y	N	P
Diabetes	Y	N	P
Excessive thirst	Y	N	P
Excessive hunger	Y	N	P
Excessive urination	Y	N	P
Excessive fatigue	Y	N	P

Emotional:

Depression/sadness	Y	N	P
Mood swings	Y	N	P
Feel out of control	Y	N	P
Feel stressed out	Y	N	P
Feel nervous	Y	N	P
Indecisive	Y	N	P
Feel isolated	Y	N	P
Uncontrolled anger	Y	N	P
Feel afraid	Y	N	P
Loss of self-esteem	Y	N	P
Feel victimized	Y	N	P
Anorexia/bulimia	Y	N	P

Diet:

Do you eat three meals daily? Y N

Blood Type? A B AB O unknown

How many glasses of water do you drink daily? ___

Do you drink caffeinated products? Y N

If so, what kind? _____

Hobbies: _____

_____

Spiritual: Please describe your spiritual beliefs or practices:

_____

_____

_____