TREE OF LIFE NATURAL MEDICINE

Dr. Andrew J. Kaufmann ND, P.L.C.

459 *N. Gilbert Road*, Suite A-135 *Gilbert*, AZ 85234

Phone: (480) 840-1596

Initial Office Visit

Personal History

Name _____ Date_____
Address _____City _____Zip _____ Phone_____
Date of Birth ___/____/_____ Age_____ Alternate phone_____
Occupation _____Birthplace_____
Date of Last Examination_____ Where_____
Your Doctor: _____Address_____ Phone_____
Emergency Contact_____Phone_____
How did you hear about us? _____ E-Mail Address _____
How would you prefer for us to contact you? Phone ___ Cell Phone ____ Email _____Mail ____

Health History

What is the main reason for seeing the doctor today? Please list in order of importance and for how long
1. _____Length of Time_____
2. _____Length of Time_____
3. _____Length of Time_____
4. _____Length of Time_____

Allergies (foods, drugs, animals, environment etc) Onset of Symptoms

_____
_____
_____
_____

Current Medications: Dosage Date Started

_____
_____
_____
_____

Vitamins or Herbs: Dosage Date Started

_____
_____
_____
_____

Have you ever seen a Naturopathic Physician, Chiropractor, Acupuncturist or other alternative healthcare provider? □ Yes □ No
Who was the practitioner and what were the results? _____
_____
How would you describe your overall state of health? □ Excellent □ Good □ Average □ Fair □ Poor
What is your blood type? _____

Previous Hospitalizations/Surgeries/Serious Illness Date City/State

_____
_____
_____
_____

Health Screening

List the date of your most recent test or exam.

Cholesterol _____ Blood Sugar _____ Dexa (Bone Density) Scan _____

Other Blood tests _____

Rectal Exam _____ Scope Lower Bowel _____Scope Upper Bowel_____

Mammogram _____ Pap Smear _____ Breast/Prostate Exam _____

Do you do self exams regularly? Which ones/when? _____

Immunization History (answer what you know)

Have you had all of your immunizations? □ Yes □ No If yes, please check all that have been administered:

□ Hep B □ DTaP or DTP □ Hib □ Polio □ MMR □ Varicella □ other_____

Were there any reactions or complications from the immunizations?_____

Personal and Family History *Check all that apply*

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Bronchitis							
Cancer							
Colon Cancer							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
Irritable Bowel							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

Birth History:
Was it a vaginal birth or a C-Section?_____ Were you breast fed? □ Yes □ No
Were there any birth complications? _____

Social History *Check all that apply:*

Marital Status:	Highest Education Completed:	Childhood Memories:	Do You Find Your Life:
□ single	□ high school	□ mostly happy	□ satisfactory
□ partnership	□ college	□ mostly painful	□ unsatisfactory
□ married	□ graduate level	□ normal	□ too demanding
□ divorced	□ other: _____	□ don't recall	□ boring
□ widowed			

Living Arrangement:
□ alone □ family □ roommate □ significant other
□ children (list name/sex/age):
_____
_____
_____

Major Stresses in Last 6 Months:
□ money □ job □ marriage □ home life □ children □ other:
_____
_____
_____

Pertinent Travel History (out of USA, epidemic areas, etc.):
_____
_____
_____

Lifestyle / Self-Care Issues
Do you smoke cigarettes? □ YES □ NO If yes, how many? #_____ Yrs. _____ Packs per day
Did you ever smoke? □ YES □ NO If yes, when did you quit? _____
Do you drink alcohol? □ YES □ NO If yes, how much? Type_____ & _____
Drinks per week? _____
Do you drink caffeinated beverages? □ YES □ NO If yes, which? _____

Do you take antacids? □ YES □ NO Do you take laxatives? □ YES □ NO
Do you take Analgesics (Advil, Tylenol, Aspirin or other anti-inflammatories) □ YES □ NO

Are you currently OR have you ever taken steroids? □ YES □ NO When and for how long? _____
Do you use recreational drugs? □ YES □ NO If yes, which? _____

Do you exercise? □ YES □ NO If no, why? _____
If yes, how much and how often? _____

Do you manage stress well? □ YES □ NO □ NOT SURE □ NEED HELP
What is you occupation?
_____
Do you enjoy your job? □ YES □ NO If no, why? _____
_____
How many hours per week do you work? _____ Do you allow time to unwind and relax? □ YES □ NO
If no, why? _____

How many hours do you sleep a night? _____
Do you sleep soundly? □ YES □ NO If no, why?_____
_____

Are you satisfied with your relationship?□ YES □ NO If no, why? _____
_____
Are you satisfied with your social life? □ YES □ NO If no, why? _____
_____
What are your Hobbies? _____
Are you satisfied with your spiritual life? □ YES □ NO If no, why? _____
_____

Height: _____ft _____in
Present weight: _____lbs Weight 1 yr ago: _____lbs Ideal Weight: _____lbs
Maximum weight as an adult and when:_____ Minimum weight as adult, and when:_____

Is your diet healthy enough? □ YES □ NO □ NOT SURE □ NEED HELP
How many ounces of water do you drink per day? _____

Typical Breakfast
_____
Typical Lunch
_____
Typical Dinner
_____
Typical Snacks
_____

Any other Digestive Problems? Gas/Bloating/Acid Reflux/Indigestion (circle those that apply)
When do you notice these symptoms _____
Anything make it better or worse? _____

Do you have any Anxiety? Yes/No (circle symptoms that apply)
Nervousness/Tightness in Chest/Difficulty taking a Deep Breath If Yes, when do you notice these symptoms
_____
_____
_____

Do you have any Neurological problems? Yes/No
Do you have Numbness/Tingling/Limbs fall asleep/Radiating Pain/Electrical Pains (circle those that apply).
If yes, when did these start? Can you describe them?
_____
_____
_____
_____

Do You Use:

□ Eyeglasses	□ Contact Lens	□ Hearing Aid	□ Brace (Neck, Back)
□ Pacemaker	□ Dentures	□ IUD, Diaphragm	□ Artificial Limbs