FROM THE DESK OF
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Greetings and welcome!

I'm excited about the opportunity to partner with you in moving toward greater health and vitality!

It is my goal to provide you with thoughtful and quality health care to create a fundamental improvement in your sense of well-being. With both of us "on board" we can make this happen! I want to challenge you as we begin, to really ask yourself: "what is that I really want from this process?" The more specifically you can answer that question, the more likely you are to experience success for yourself, and the better I can "dial-in" to meet your specific needs.

These are just a few housekeeping issues to share with you before we begin this journey.

If you need to get in touch with me, the email address above is a good place to start. This is intended as a way for you to communicate with short questions or challenges/problems you might have as we move along.

Longer questions or more involved issues need to be addressed in your office or phone consultations. I do check my email messages regularly and I will always respond to your inquiry as soon as I am able. You can also call me at the above number if you don't have access to the internet.

An important part of this process is patient education. Along those lines, I would like to share with you key principles of how we will be looking at the challenges that face you, as well as what steps are necessary in order to correct those. You will receive regular communications from me (typically via email) that address the important elements in the way I work with patients to regain their health. Given the practical benefit of these educational pieces, I would encourage you to forward these on to others you might know that could benefit from these ideas.

Please keep in mind that I require 24 hours to cancel appointments.

If you have questions about anything that pertains to your care, please do not hesitate to ask. When it comes to holistic medicine, education is very important and I will do my best to explain all of my findings to you in a clear manner.

If you need to pick up medicinary items please call us in advance by at least 2 hours so that we can have them ready for you.

I sincerely look forward to working with you - Allan A. Harris ND, LAc.

Circle of Health Clinic
New Patient Information

Date _____

Name _____ DOB _____

Address _____

City/State/Zip _____

Phone (H) _____ (W) _____

Email (Often times the Doctor and Patient will converse via email. This is a great way to ask the Doctor questions following a visit): _____

Employer _____

Address _____

City/State/Zip _____

Call in the event of an Emergency _____

Relationship _____

Phone (H) _____ (W) _____

Address _____

City/State/Zip _____

Complete only if the party responsible for payment is different than the patient listed above:

Person responsible for payment _____

Address _____

City/State/Zip _____

Phone (H) _____ (W) _____

MEDICATION LIST

Name: _____ **Birthdate:** _____

Please list all medications you are currently taking.

	MEDICATIONS	Date Began	Dosage
1			
2			
3			
4			
5			

OFFICE USE ONLY

	ISSUES	Date Noted	ICD-9 CODE
1			
2			
3			
4			
5			

OTHER PERTINENT INFORMATION

_____

_____

_____

_____

Name: _____ Date: _____

Birthdate: _____ Gender: _____

Circle of Health Clinic - Dr. Allan A. Harris ND, LAc

. Please list your five major health complaints in order of importance and ***rate them on a scale of 0 to 4 - with 4 being the Most Severe***

	Please choose one				
	0	1	2	3	4
1. _____	○	○	○	○	○
2. _____	○	○	○	○	○
3. _____	○	○	○	○	○
4. _____	○	○	○	○	○
5. _____	○	○	○	○	○

SECTION A

Family Medical History

☐ Allergies	☐ Arteriosclerosis	☐ Cancer	☐ Diabetes	☐ Seizures
_____	☐ Asthma	_____	☐ Heart Disease	☐ Stroke
_____	☐ Alcoholism	_____	☐ High Blood Pressure	☐ Thyroid Disease

Your Past Medical History

☐ AIDS/HIV	☐ Cancer	☐ High Blood Pressure	☐ Polio	☐ Surgery (list)
☐ Alcoholism	☐ Chicken Pox	☐ Measles	☐ Rheumatic Fever	_____
☐ Allergies	☐ Diabetes	☐ Mold exposure	☐ Scarlet Fever	_____
☐ Anemia	☐ Emphysema	☐ Mold sensitivity	☐ Seizure	☐ Major Trauma
☐ Appendicitis	☐ Epilepsy	☐ Multiple Sclerosis	☐ Stroke	(Auto Accident, fall, etc.)
☐ Arteriosclerosis	☐ Goiter	☐ Mumps	☐ Tuberculosis	_____
☐ Asthma	☐ Gout	☐ Pacemaker	☐ Typhoid Fever	_____
☐ Birth Trauma	☐ Heart Disease	☐ Parasites	☐ Ulcers	☐ Other (Specify)
(your own birth)	☐ Hepatitis	☐ Pleurisy	☐ Venereal Disease	_____
☐ Bone loss	☐ Herpes	☐ Pneumonia	☐ Thyroid Disorder	_____
☐ Taken antibiotic for 1 month or more or 3 rounds in the last 12 months.				_____

Environmental Exposure

☐ New construction materials	☐ Pesticides	☐ Cleaning Products	☐ Heavy Metals
☐ Industrial toxins	☐ Solvents	☐ Exhaust and/or smoke	☐ Mold

Your Diet

Appetite:	☐ Low	☐ Coffee	☐ Artificial Sweeteners	☐ Salty Foods
	☐ High	☐ Softdrinks	☐ Sugar	☐ Thirst for water

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Your Lifestyle

☐ Alcohol	☐ Stress	Regular exercise:	Type:	_____	Frequency:	_____
☐ Tobacco	☐ Occupational		Type:	_____	Frequency:	_____
☐ Marijuana	Hazard (list below)		Type:	_____	Frequency:	_____
☐ Drugs	_____	Sleep:	Average number of hours per night:			_____

Gynecology (Women Only)

Age menses began	_____	Date of last period	_____	# of pregnancies	_____
Length of cycle	_____	Age at menopause	_____	# live births	_____
Duration of flow	_____	Date of last pap	_____	# preterm births	_____
				# Abortions	_____

SECTION B

Rate each of your symptoms on a scale of 0 to 4

With '0' being Never and '4' being Most Severe

Base your numbers on your typical health profile for the last 2 months

General Symptoms (on a scale of 0 to 4 with 4 being the most severe)

- ____ **Fequent Illness**
- ____ **Fatigue/sluggishness**
- ____ **Apathy/lethargy**
- ____ **Hyperactivity**
- ____ **Restlessness**
- ____ Poor Appetite
- ____ Heavy Appetite
- ____ Strong thirst
- ____ Lack of thirst
- ____ Poor Sleep
- ____ Heavy Sleep
- ____ Sleepy after meals
- ____ Bitter taste in mouth
- ____ Grief
- ____ Seasonal allergies
- ____ Dream disturbed sleep
- ____ Cold Hands or Feet
- ____ Poor Circulation
- ____ Addictive nature
- ____ Crave chocolate
- ____ Difficulty swallowing
- ____ Difficulty falling asleep
- ____ Vertigo or Dizziness
- ____ Bleed Easily
- ____ Bruise Easily
- ____ Lack of strength
- ____ Feel warm
- ____ Feel Cold
- ____ Night Sweats
- ____ Bodily Heaviness
- ____ Food allergies/sensitivity
- ____ Crave bread or noodles
- ____ Poor tolerance to sugar
- ____ Crave sweets
- ____ Clench or grind teeth
- ____ Fear of impending doom
- ____ Worrier, apprehensive
- ____ Restless leg syndrome
- ____ Sleepy in the afternoon
- ____ Shortness of Breath
- ____ Sweat Easily
- ____ Nose bleeds easily
- ____ or tend to bruise easily
- ____ Slow starter in the morning
- ____ Crave coffee or sugar in the afternoon to maintain energy
- ____ Pain between shoulder blades
- ____ Sensitive to chemicals or fumes
- ____ Chronic fatigue or fibromyalgia
- ____ Eat dessert or sugary snacks
- ____ Cuts heal slowly or scar easily
- ____ Specific foods cause bloating & fatigue
- ____ Awaken after a few hours of sleep
- ____ Shaky or irritable if meals are delayed
- ____ Muscle cramping,
- ____ with or with out exertion
- ____ Strong light irritates eyes
- ____ Calm on the outside, troubled inside
- ____ Peculiar taste in mouth

Describe: _____

_____

Women:

- ____ Breast tenderness
- ____ Painful intercourse
- ____ Vaginal dryness
- ____ Vaginal itchiness
- ____ Excess facial or body hair

Men:

- ____ Night sweats
- ____ Prostate Problems
- ____ Impotence
- ____ Premature ejaculation
- ____ Nocturnal Emission

Eyes, Throat, Head, Ears, Mouth, Nose (on a scale of 0 to 4 with 4 being the most severe)

- ____ **Watery/Itchy Eyes**
- ____ **Swollen, Red, sticky Eyelids**
- ____ **Bags/dark circles under eyes**
- ____ **Blurred/tunnel Vision**
- ____ Eye strain
- ____ Eye Pain
- ____ Spots in Eyes
- ____ Poor Vision
- ____ Dry Eyes
- ____ Night blindness
- ____ Red Eyes
- ____ Glaucoma
- ____ Cataracts
- ____ Dry Mouth
- ____ Excessive Saliva
- ____ Excessive Phlegm
- ____ (Color of Phlegm)
- ____ Recurrent Sore Throat
- ____ Swollen Glands
- ____ Lumps in Throat
- ____ Enlarged Thyroid
- ____ Nose Bleeds
- ____ **Stuffy Nose**
- ____ **Sinus Problems**
- ____ **Hay Fever**
- ____ **Sneezing Attacks**
- ____ **Excessive Mucus**
- ____ **Itchy Ears**
- ____ **Earaches/ear infection**
- ____ **Drainage from Ear**
- ____ **Ringing in Ears/Hearing Loss**
- ____ **Headaches**
- ____ **Faintness**
- ____ **Dizziness**
- ____ **Insomnia**
- ____ Migraines
- ____ Concusions
- ____ Other Head/Neck Problems
- ____ Teeth Problems
- ____ Grinding Teeth
- ____ TMJ
- ____ Facial Pain
- ____ Gum Problems
- ____ Sores on lips
- ____ Sores on tongue
- ____ **Chronic coughing**
- ____ **Gagging-need to clear throat**
- ____ **Sore Throat, hoarseness, loss of voice**
- ____ **Swollen or discolored tongue, gums, lips**
- ____ **Canker Sores**

Respiratory (on a scale of 0 to 4 with 4 being the most severe)

- ____ **Chest Congestion**
- ____ **Asthma/bronchitis**
- ____ **Shortness of Breath**
- ____ **Difficulty Breathing**
- ____ Tight Chest
- ____ Pneumonia
- ____ Coughing Blood
- ____ Cough
- ____ Wet or Dry?
- ____ Thick or Thin?
- ____ (Color of Phlegm)

Cardiovascular (on a scale of 0 to 4 with 4 being the most severe)

- ____ **Irregular/skipped Heart beat**
- ____ **Rapid/pounding heart rate**
- ____ **Chest Pain**
- ____ Fainting
- ____ Heart Palpitations
- ____ Difficulty Breathing
- ____ High Blood Pressure
- ____ Low Blood Pressure
- ____ Phlebitis
- ____ Blood Clots

Other: _____

Gastrointestinal (on a scale of 0 to 4 with 4 being the most severe)

____ **Nausea/vomiting**	____ Intestinal Cramping	____ Itchy anus	**Bowel Movements:**
____ **Diarrhea**	____ Laxative Use	____ Burning anus	____ Light or clay colored stools
____ **Constipation**	____ Black stools	____ Rectal Pain	Color _____
____ **Bloating**	____ Bloods stools	____ Hemorrhoid	Odor _____
____ **Belching/passing gas**	____ Mucous in stools	____ Anal Fissures	Frequency _____
____ **Heartburn**	____ Acid Reflux	____ Bad breath	Texture _____
____ **Intestinal/stomach Pain**	____ Hiccup		Form _____

Musculoskeletal (on a scale of 0 to 4 with 4 being the most severe)

____ **Pain/ache in joints**	____ **Pain/ache in muscles**	____ Neck/Shoulder	____ Low Back Pain
____ **Arthritis**	____ **Feeling weak/tired**	____ Muscle Pain	____ Upper Back Pain
____ **Stiffness or limitation of movement**			____ Rib Pain

Skin and Hair (on a scale of 0 to 4 with 4 being the most severe)

____ **Acne**	____ Brittle or weak nails	____ Dandruff	____ Change in Hair/skin texture
____ **Hives, Rashes, Dry Skin**	____ Eczema	____ Itching	____ Fungal Infections
____ **Hair Loss**	____ Psoriasis	____ Ulcerations	____ Dryness
Flushing/Hot Flashes			
Excessive Sweating			

Neuropsychological & Emotions (on a scale of 0 to 4 with 4 being the most severe)

____ **Poor Memory**	____ **Slurred speech**	____ **Mood Swings**
____ **Confusion/poor comprehension**	____ **Learning Disabilites**	____ **Anxiety, fear, nervousness**
____ **Poor concentration**	____ Brain Fog	____ **Anger, irritability, aggressiveness**
____ **Poor physical coordination**	____ Seizures	____ **Depression**
____ **Difficulty making decisions**	____ Ticks	
____ **Stuttering/stammering**	____ Numbness	

Genito - Urinary (on a scale of 0 to 4 with 4 being the most severe)

____ **Frequent/urgent urination**	____ Cloudy Urine	____ Wake to urinate	____ Increased libido
____ **Genital Itch or discharge**	____ Incomplete Urination	____ Bedwetting	____ Decreased libido
____ Darkly Colored Urine	____ Unable to Hold Urine	____ Kidney stone	

Weight (on a scale of 0 to 4 with 4 being the most severe)

____ **Binge Eating/drinking**	____ **Excessive weight**	____ **Water retention**	____ Difficulty gaining weight, even with normal appetite
____ **Crave certain foods**	____ **Compulsive eating**	____ **Underweight**	____ Difficulty losing weight

Other: Please list symptoms and severity

____ _____
____ _____
____ _____
____ _____

SECTION C

Miscellaneous

✔ Any that apply

____ Do you feel like skipping breakfast?	____ Wheat or grain sensitivity	Daily water intake _____ oz.
____ If drinking alcohol, easily intoxicated	____ Dairy sensitivity	
____ Long term use of prescription medications	____ Do you wear prescription lenses?	
____ Allergies to medications? *Please list:* _____		

Please list anything else you would like us to know: _____

_____

_____

_____

How did you hear about us? ✔ Any that apply

____ Physician referral	____ Referral from a friend	____ Insurance Company Provider Directory
____ Internet search	____ Yellow pages	____ Other (Please list) _____

1 Why did you choose to come to our clinic?

_____

_____

2 What expectations do you have from your care at this clinic?

_____

_____

3 Are you here primarily for Acupuncture, Naturopathic care, or both? _____

4 What is your present level of commitment to address/change your current lifestyle and its potential impact on your health? On a scale of 1 to 5 with 5 being the most commited _____

5 What potential obstacles do you see in making a change in your lifestyle and following the direction necessary to support your health?

_____

_____

6 Who do you know that will sincerely support you in your lifestyle changes necessary for you to change your health?

_____

7 What do you Love to do?

_____

_____

Save & Print OR Email to alharrisndlac@yahoo.com