North Star Naturopathic Medicine

The Medical Practice of Dr. Christina Caselli, ND – Mount Shasta, California

Patient Information

Name

DOB

Gender M_____ F _____

Email

Would you like to be on our email list? Yes________

Address

Home Phone

Mobile Phone

Emergency Contact

Name Relationship to you Phone

Preferred way to receive correspondence and messages: Mobile Phone_______ Home Phone_______ E-mail______

How did you find us?
Doctor Referral _______Patient Referral _______Web search _______

If you were referred, please let us know by whom:

Have you seen a doctor that practices natural or integrative medicine before? Yes____ No____
If so, what type of natural medicine-oriented clinicians have you visited?

Naturopathic Doctor______ Holistic MD/DO_______ Acupuncturist_______ Chiropractor______ Other:_______________

Do you have questions about Naturopathic Medicine?

What are your health goals?

Do you have health insurance? Yes______ No______
If Yes, HMO or PPO? Who is your insurance carrier?

Please list other health care providers you are currently working with:

Name	Specialty	Contact Info
1.		
2.		
3.		

Current Health Concerns

Please list by order of importance to you. (Attach another list if necessary)	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe:
1.		
2.		
3.		
4.		
5.		
6.		

Personal & Family Health History

Date of last physical exam?	Date of last Dexa Scan (bone density scan)?
Date of most recent blood work?	Date of last colonoscopy?
Mother: ❑ Living ❑ Deceased Age: Cause if deceased: Father: ❑ Living ❑ Deceased Age: Cause if deceased:	Sibling: Y_____ N_____ Number living: Number deceased: Gender: Age(s): Cause(s) if deceased: 1. 2. 3. 4.

Drug Allergies

Any known medication allergies? Yes________ No__________

If Yes, which medications:

What allergic reaction symptoms do you experience?

Past Medical History

Please list any hospitalizations and any major past illnesses or injuries (e.g., broken bones, surgeries, etc.):

Prescribed medications and over the counter medications – attach a separate list if necessary

Medication Name	Dose	When started?	Why?
1.			
2.			
3.			
4.			
5.			

Supplements – please list all vitamins/botanicals, homeopathics, etc.

Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started?	Why?
1.			
2.			
3.			
4.			
5.			

Sense of Well-being

Rate your sense of wellbeing from 1-10 (1 = Very Low, 10 = High)	Rate your stress levels from 1-10 (1 = Very Low, 10 = High)

What do you do to cope with stress and maintain well-being?

What challenges do you face with your efforts to maintain health?

Where do you feel you could use more support?

Diet

Do you follow any special diet or restrictions?	Are there foods you crave strongly?
What foods make you feel poorly? Explain:	What foods make you feel the best? Explain:

How would you describe your relationship with food?

Please list typical foods consumed daily – specify typical times of day for each:

Breakfast	
Lunch	
Dinner	
Snacks	
Sweets	
Water	How much? Tap, filtered, bottled?

Please check the appropriate box below to indicate the frequency of consumption:

	Daily	Weekly	Monthly	Occasionally (1-2 x per month)	Rarely (1-2 x per year)	Never
Sugar						
Artificial sweeteners						
Fast food						
Fried food						
Processed food						
Flour/baked goods						
Caffeine						
Soda						
Alcohol						

Notes/details:

Habits

Do you smoke cigarettes? Y_______ N_________	Packs per day?	Duration of habit?
	Past Use?	If so, how long ago did you quit?
Do you use recreational drugs? Y/N	If Y, what type?	
	How often?	
	Past Use?	If so, how long ago did you quit?
Have you ever been treated for drug/alcohol addiction? Y__N__	If Y, describe:	How long ago?

Occupation

What is your occupation?	Do you like your work? Y_____ N_____
Number of hours worked per week:	Do you like your work environment? Y_____ N______ If no, please explain:

Sleep

How many hours of sleep do you get regularly each night?		Time you go to bed:
Do you fall asleep easily? Y_____ N_____	Do you sleep soundly? Y_____ N_____	Time you get up:
Do you wake rested? Y_____ N______	What is your AM mood like?	

Notes:

Exercise

Do you exercise regularly? Y_____ N_____	How often?	For how long?
What type(s) of exercise do you do?		

Relationship Status

_____Single _____In a relationship _____Married _____ Divorced _____Widowed	Happy with your status? Y_____ N_____

Do you have children**?** Y_____ N_____ If yes, number, age and gender of children:

Personal & Family Diagnosed Health Conditions	YES	Who? Indicate self or a specific family member	Notes:
ADD/ADHD	❑		
Alcohol/Drug Addiction	❑		
Anemia	❑		
Alzheimer's/Dementia	❑		
Arthritis (Osteo or Rheumatoid?)	❑		
Asthma	❑		
Autoimmune Diseases	❑		
Blood disorder	❑		
Cancer	❑		What kind? Age diagnosed?
Cardiovascular Disease	❑		
Depression	❑		
Diabetes Type 2	❑		
Diverticulosis	❑		
Eating Disorder	❑		
Eczema	❑		
Epilepsy/Seizure Disorder	❑		
Fibromyalgia	❑		
Gallstones/Gall Bladder Disease	❑		
Gout	❑		
High Cholesterol	❑		
HIV/Aids	❑		
Hypertension	❑		
Inflammatory Bowel Disease	❑		
Kidney Disease	❑		
Learning Disability	❑		
Liver Disease - If Yes, please specify:	❑		
Mental illness – If Yes, please specify:	❑		
Neurologic Disorder	❑		
Osteopenia/Osteoporosis	❑		
Stomach or Duodenal Ulcers	❑		
Stroke	❑		
Thyroid disease	❑		
Other:	❑		

Following Sections Optional			
Review Of Systems – Check/Circle appropriate responses below				

Neurologic & Hormonal:	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
"Brain Fog"/Memory difficulty	❑	❑	1 2 3	
Depression	❑	❑	1 2 3	
Irritability	❑	❑	1 2 3	
Anxiety	❑	❑	1 2 3	
Panic attacks	❑	❑	1 2 3	
Poor stamina	❑	❑	1 2 3	
Fatigue	❑	❑	1 2 3	Recent onset or Chronic?
Sensitive to light	❑	❑	1 2 3	
Sensitive to smells	❑	❑	1 2 3	
Vertigo/dizziness	❑	❑	1 2 3	
Fainting	❑	❑	1 2 3	
Seizures	❑	❑	1 2 3	
Thirst ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Appetite ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Hypoglycemia -need to eat often or feel weak, irritable, or shaky	❑	❑	1 2 3	
Weight ❑ Gain ❑ Loss	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	How much did you weigh last year? 5 years ago? 10 years ago? What is your ideal weight?
Energy			Rate from 1-10 (1 = Low, 10 = High)	Best time of day? Hardest time of day? Consistent all day?
Sweat ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Body Temperature ❑ Cold ❑ Hot	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	

Head:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Hair	❑	❑		❑ Dry ❑ Thinning ❑ Excessive shedding ❑ Balding - Where? ❑ Alopecia ❑ Male Pattern ❑ Other:
Headaches	❑	❑	1 2 3	Location of pain? Sensation of pain?
Migraines	❑	❑	1 2 3	
Eyes:				
Dryness	❑	❑	1 2 3	
Tearing	❑	❑	1 2 3	
Cataract(s)	❑	❑	1 2 3	
Glaucoma	❑	❑	1 2 3	
Vision	❑	❑		Change in vision?
Under-eye bags /dark circles	❑	❑	1 2 3	
Ears:				
Ear infections	❑	❑	1 2 3	
Excessive earwax build-up	❑	❑	1 2 3	
Tinnitus	❑	❑	1 2 3	
Nose:				
Nasal congestion	❑	❑	1 2 3	
Nasal dryness	❑	❑	1 2 3	
Nose runs	❑	❑	1 2 3	
Nose bleeds	❑	❑	1 2 3	
Post-nasal drip	❑	❑	1 2 3	
Sinus pressure	❑	❑	1 2 3	
Sinus infections	❑	❑	1 2 3	
Mouth/Throat:				
Canker sores/oral lesions	❑	❑	1 2 3	
Periodontal disease	❑	❑	1 2 3	
Amalgam fillings	❑	❑	1 2 3	How many?
Hoarse voice	❑	❑	1 2 3	

Cardiovascular:	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
Shortness of breath	❑	❑	1 2 3	
High blood pressure	❑	❑	1 2 3	
Low blood pressure	❑	❑	1 2 3	
Chest pain	❑	❑	1 2 3	
Palpitations/"flutters"	❑	❑	1 2 3	
Heart rhythm abnormalities	❑	❑	1 2 3	
Murmur	❑	❑	1 2 3	
Poor circulation: cold hands/feet	❑	❑	1 2 3	
Varicose veins	❑	❑	1 2 3	
Leg cramps	❑	❑	1 2 3	
Loss of hair on lower limbs	❑	❑	1 2 3	
Respiratory:				
Cough	❑	❑	1 2 3	
Wheezing	❑	❑	1 2 3	
Bronchitis	❑	❑	1 2 3	
Pneumonia	❑	❑	1 2 3	
Positive TB test	❑	❑	1 2 3	
Gastro-Intestinal:				
Acid reflux/heartburn	❑	❑	1 2 3	
Abdominal pain	❑	❑	1 2 3	
Ulcer(s)	❑	❑	1 2 3	
Intestinal cramping	❑	❑	1 2 3	
Abdominal bloating	❑	❑	1 2 3	
Belching	❑	❑	1 2 3	
Nausea	❑	❑	1 2 3	
Vomiting	❑	❑	1 2 3	
Bowel Movements Constipation Diarrhea Blood or mucus in stool	 ❑ ❑ ❑	 ❑ ❑ ❑	 1 2 3 1 2 3 1 2 3	Frequency: ❑ Multiple BMs daily ❑ 1x per day ❑ Every other day ❑ Other: Consistency: ❑ Loose ❑ Soft ❑ Formed ❑ Hard
Flatulence	❑	❑	1 2 3	
Itching anus	❑	❑	1 2 3	
Rectal pain/bleeding	❑	❑	1 2 3	
Hemorrhoids	❑	❑	1 2 3	

Immune system:	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
Frequent colds/flus	❑	❑	1 2 3	
Long recovery time from illness	❑	❑	1 2 3	
Frequent antibiotic use	❑	❑	1 2 3	
Frequent antibiotic use	❑	❑	1 2 3	Frequent antibiotic use
Chronic inflammation	❑	❑	1 2 3	Chronic inflammation
Chronic viral infections (EBV, CMV, HIV)	❑	❑		Chronic viral infections (EBV, CMV, HIV)
Swollen glands	❑	❑	1 2 3	Swollen glands
Night sweats	❑	❑	1 2 3	Night sweats
Genito-Urinary:				
Frequent urination	❑	❑	1 2 3	❑ Day ❑ Night
Urinary incontinence	❑	❑	1 2 3	❑ Day ❑ Night
Blood in urine	❑	❑	1 2 3	For how long?
Urinary tract infections	❑	❑	1 2 3	
Change in libido	❑	❑	1 2 3	❑ Increased ❑ Decreased
Sexually active	❑	❑		If Y, frequency of sexual activity? Number of partners in the last year? Satisfied with your sex life? Y____N_____
Sexually transmitted infections	❑	❑		❑ HIV ❑ Herpes ❑ HPV/Warts ❑ Gonorrhea ❑ Chlamydia ❑ Syphilis ❑ Hepatitis ❑ Other
Birth control/ barrier method used?	❑	❑		If yes, what type(s)
Impaired fertility? Y_____ N_____	❑	❑		
Musculoskeletal:				
Joint Pain	❑	❑	1 2 3	Where?
Muscle: Weakness Pain	❑ ❑	❑ ❑	1 2 3	
Numbness or Tingling	❑	❑	1 2 3	

Skin:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Bruise easily	❑	❑	1 2 3	
Hives	❑	❑	1 2 3	
Rashes	❑	❑	1 2 3	
Frequent fungal infections	❑	❑	1 2 3	
Flaky scalp	❑	❑	1 2 3	
Psoriasis	❑	❑	1 2 3	
Eczema	❑	❑	1 2 3	
Acne	❑	❑	1 2 3	
Precancerous/cancerous growths	❑	❑	1 2 3	
Moles	❑	❑	1 2 3	
Warts	❑	❑	1 2 3	
Female Health:				
Vaginal symptoms: Itchiness Discharge Odor Dryness Painful intercourse Lacerations/tears Yeast infections Bacterial vaginosis	 ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑	 ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑	 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3	Date of last gynecologic exam: Ever had an abnormal pap? Y____ N____ If yes, when?
Irregular bleeding	❑	❑	1 2 3	
Menstrual cramps	❑	❑	1 2 3	
Mood volatility Irritability Weepiness	❑ ❑ ❑	❑ ❑ ❑	1 2 3 1 2 3 1 2 3	
Breast tenderness Lumps/Cysts	❑ ❑	❑ ❑	1 2 3	
Water retention	❑	❑	1 2 3	
Abdominal bloating	❑	❑	1 2 3	
Endometriosis	❑	❑	1 2 3	
Uterine fibroids	❑	❑	1 2 3	
Ovarian cysts	❑	❑	1 2 3	
Hot flashes/sweats	❑	❑	1 2 3	Day Night

Reproductive history:	
Number of pregnancies: Number of miscarriages: Number of abortions: Number of births: Date of last birth:	Date of last menstrual period: *Cycle length* regular? Y_____ N_____ ❑ Short ❑ Long ❑ Irregular *Blood flow:* how many days? ❑ Light ❑ Medium ❑ Heavy ❑ Large clots
Oral contraceptives, HRT/BHRT or other hormone treatment/ replacement used? Y_____ N______	If so what has been used and how long?