



J.J. Pursell N.D., LAc., Herbalist

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(503) 234-7801

Name _____ Date _____

Age _____ Date of Birth ____ / ____ / ____ Gender: female _____ male _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home) _____ (work) _____

Occupation _____ Hours per week _____ Retired _____

Employer _____ S.S.# _____

Email address _____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____

Partnership _____

Live with: Spouse _____ Partner _____ Parents _____ Children _____

Friends _____ Alone _____

Who referred you ? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental factors? _____

Current Medications

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Tobacco	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N	Sleeping pills	Y	N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

- 1) _____ 4) _____
 2) _____ 5) _____
 3) _____ 6) _____

Typical Food Intake

- Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 To drink: _____

GENERAL

Weight _____ lbs. Weight 1 year ago _____ lbs.
 Maximum Weight _____ When _____
 Height _____
 When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS

Y = a condition you have now P = a condition you have had before
 N = never had

FOR THE FOLLOWING, PLEASE CIRCLE

MENTAL/EMOTIONAL

Mood Swings?	Y	N	P	Anxiety or nervousness?	Y	N	P
Poor concentration?	Y	N	P	Memory problems?	Y	N	P

ENDOCRINE

Hypothyroid?	Y	N	P	Heat or cold intolerance?	Y	N	P
Hypoglycemia?	Y	N	P	Diabetes?	Y	N	P
Fatigue?	Y	N	P	Seasonal depression?	Y	N	P

IMMUNE

Vaccinations?	Y	N	P	Reactions to vaccinations?	Y	N	P
Chronic Fatigue Syndrome?	Y	N	P	Chronic infections?	Y	N	P
Chronically swollen glands?	Y	N	P	Slow wound healing?	Y	N	P

SKIN

Rashes?	Y	N	P	Eczema, Hives?	Y	N	P
Acne, Boils?	Y	N	P	Itching?	Y	N	P

HEAD

Headaches?	Y	N	P	Migraines?	Y	N	P
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Head injury? Y N P

EARS

Earaches? Y N P Impaired hearing? Y N P
Dizziness? Y N P Ringing? Y N P

NOSE AND SINUSES

Frequent colds? Y N P Nose Bleeds? Y N P
Stiffness? Y N P Hayfever? Y N P
Sinus problems? Y N P Loss of smell? Y N P

MOUTH AND THROAT

Frequent sore throat? Y N P Sore tongue/lips? Y N P

RESPIRATORY

Cough? Y N P Wheezing? Y N P
Asthma? Y N P Bronchitis? Y N P

CARDIOVASCULAR

Heart disease? Y N P High/Low Blood Pressure? Y N P
Palpitations/Fluttering? Y N P

GASTROINTESTINAL

Heartburn? Y N P Belching or passing gas? Y N P
Change in thirst? Y N P Change in appetite? Y N P
Bowel Movements Y N P Constipation? Y N P
How often? _____ Diarrhea? Y N P
Is this a change? _____

URINARY

Increased frequency? Y N P Frequency at night? Y N P
Frequent infections? Y N P

MUSCULOSKELETAL

Joint pain or stiffness? Y N P Arthritis? Y N P
Muscle spasms or cramps? Y N P

MENSTRUAL HISTORY

Age of first menses _____ Was your menses regular (monthly) after first menses? Y N

Age at Menopause _____

How many days in your cycle _____

How many days do you bleed? _____

What color (s) is the blood? _____

Cramping: Y N P

If yes, what days do you experience cramping? _____

Clots? Y N P

Spotting? Y N P

Breast Tenderness? Y N P

Bloating? Y N P

Increase in appetite? Y N P

Hot Flashes? Y N P

History of ovarian cysts? Y N P

History of endometriosis? Y N P

History of chronic discharge? Y N P

Pain with sex? Y N P

Birth control history: _____

HABITS

Do you exercise?	Y	N		
If yes, what kind? _____			How often?	
Average 6-8 hrs. sleep?	Y	N	Enjoy your work?	Y N
Sleep well	Y	N	Take vacations?	Y N
Awaken rested?	Y	N	Spend time outside?	Y N
Have a supportive relationship?	Y	N	Any major traumas?	Y N P
Have a history of abuse?	Y	N	P	
Use recreational drugs?	Y	N	P	
Treated for drug dependence?	Y	N	P	
Do you eat 3 meals a day?	Y	N	P	Use alcoholic beverages? Y N P
Do you eat out often?	Y	N	P	Treated for alcoholism? Y N P
Do you go on diets often?	Y	N	P	Do you use tobacco? Y N P
Do you drink coffee?	Y	N	P	
Do you drink black tea?	Y	N	P	
Do you drink cola?	Y	N	P	
Do you eat refined sugar?	Y	N	P	
Do you add salt?	Y	N	P	

Is there any information about your health you would like to add?

Welcome! I'm happy to help you! If you have any questions, just ask!

The first initial visit will be focused on your health history. I am committed to improving your health. Please take a moment and determine what level of commitment you are willing to make in this process. At the first follow-up visit I will be able to determine the appropriate treatment plan. Payment is required at time of service. The initial visit is \$150 for 1 hour. Follow-up visits are \$85.

Cancellations must be made 24 hours in advance, if not a \$40 fee is assessed. Thank you.