SoundMind Medicine, LLC
Debbie Miller, ND, BCB
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ph: 206.376.7954 | fax: 206.267.0154

Thank you for taking the time to fill out this form. Please answer the questions as throughly as possible. This will help us determine the best treatment plan for you going forward. **All of your answers will be kept confidential.** I look forward to partnering with you to help you work towards your goals.

Patient Information

Last Name: _____ First Name: _____ Middle name: _____

Date of Birth & Age: _____ Social Security #:_____

Gender Identification: _____ Pronoun preference: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

Is e-mail a good way to correspond with you? (Circle one) **Yes / No**

Home Ph: (_____)_____ ☐ (check box if preferred contact number)

Work Ph: (_____)_____ ☐ (check box if preferred contact number)

Cell Ph: (_____)_____ ☐ (check box if preferred contact number)

May we leave confidential voice-mail messages for you at any of these numbers?

(Circle one) **Yes / No** Please specify which one(s): **Home / Work / Cell**

Other name(s) that records may be kept under: _____

Mother's Name (minors only): _____

Father's Name (minors only): _____

Emergency Contact: _____ Relationship: _____

Emergency contact's phone #: (_____)_____

Relationship status (Circle one):

Single / Married / Separated / Divorced / Domestic partnership / Significant other / Other:_____

Employment status (Circle one):

Full time / Part time / Student / Retired / Other: _____

Occupation(s): _____

Name of partner/spouse: _____

Names and ages of any children: _____

Were you referred by another practitioner? (Circle one) Yes / No

If yes, who? _____

If no, how did you hear this clinic? _____

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Please list your primary physician(s) and contact information:

Name: _____ Number: _____

Name: _____ Number: _____

Name: _____ Number: _____

Health & History Questionnaire

Describe the main problem you would like to address:

_____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

_____

_____

When did you first notice symptoms? _____

_____

Have you been given a diagnosis for the problem by a physician? If yes, what was the diagnosis?

_____

What treatments have you tried for this problem? _____

_____

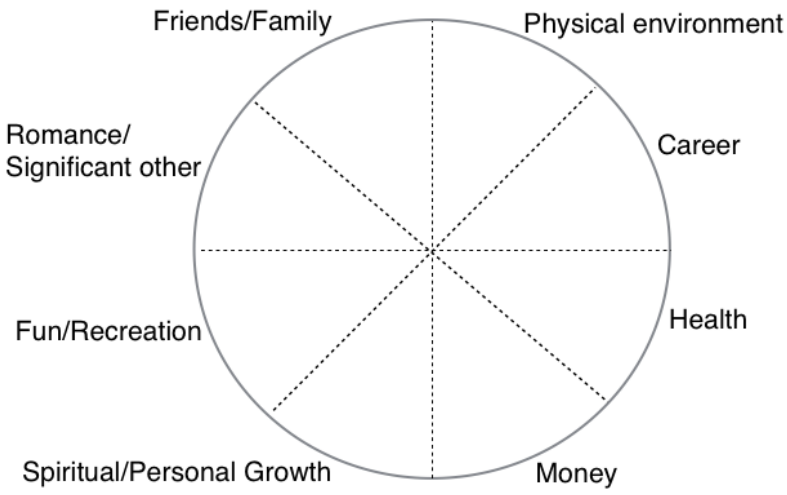
What are your goals and expectations for biofeedback training?_____

_____

Wheel of Balance

Wellness is a balance of many factors. Using the circle, starting with the center and moving outwards, shade your level of Satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.



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Medical History

List your **current medications** with dosages and frequency (you may write on the back if you need more space). Please include **prescriptions and over the counter** medications:

Medication	**Dosage** *(i.e. 500mg, 88mcg, etc.)*	**Directions** *(i.e. one tablet once daily, as needed, etc.)*

Are you **allergic to any medications**? Yes / No

If yes, please list which one(s) and your reactions:_____

_____

_____

List any **vitamins/supplements** you take with brand, dosages, and frequency (you may write on the back if you need more space). Please include supplements, vitamins, herbs, homeopathic remedies, probiotics, etc.:

Supplement & Brand *(i.e. Vitamin D 1000 by Thorne)*	**Dosage** *(i.e. 500mg, 88mcg, etc.)*	**Directions** *(i.e. one tablet once daily, as needed, etc.)*

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List any past surgeries and hospitalizations with dates:

_____

_____

_____

_____

Please put a check next to conditions you have experienced within the last three months unless otherwise specified. Indicate the length of time you have had this condition:

General:

☐Changes in appetite
☐Localized weakness
☐Weight gain
☐Sweating easily
☐Night sweats
☐Chills
☐Sudden drop in energy (time of day)? _____
☐Insomnia
☐Cravings
☐Weight loss
☐Tremors
☐Fever
☐Dream disturbed sleep
☐Strong thirst
☐Bleeding or bruising easily
☐Poor balance
☐Heat intolerance
☐Cold intolerance
☐Chronic fatigue

☐Other unusual of abnormal conditions you have noticed in your general sense of health?
_____

Hair & Skin:

☐Rashes
☐Itching
☐Dandruff
☐Ulcerations
☐Eczema
☐Hair loss
☐Hives
☐Recent moles

☐Changes in hair or skin texture: _____
☐Any other hair/skin problems?_____

Head, Eyes, Ears, Nose, Throat:

☐Dizziness
☐Use glasses or contacts
☐Poor vision
☐Night blindness
☐Color blindness
☐Cataracts
☐Sinus problems
☐Teeth grinding
☐Teeth problems
☐Concussions
☐Spots in front of eyes
☐Blurred vision
☐Poor hearing
☐Recurrent sore throats
☐Sores on lips or tongue
☐Headaches
☐Migraines
☐Eye pain
☐Earaches
☐Eyestrain
☐Nosebleeds
☐Facial pain
☐Jaw clicks or pain

Any other head or neck problems:_____

Cardiovascular:

☐Dizziness upon standing
☐Palpitations
☐Cold hands or feet
☐Blood clots
☐Low blood pressure
☐High blood pressure
☐Swelling of hands
☐Chest pain
☐Chest tightness

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☐Swelling of feet ☐Phlebitis ☐Rapid heart beat
☐Fainting ☐Poor wound healing ☐Slow heart beat
Any other heart or vessel problems?_____

Respiratory:
☐Cough ☐Difficulty breathing when lying down ☐Asthma
☐Bronchitis ☐Pneumonia
☐Difficulty breathing ☐Coughing up blood ☐Chemical exposure
☐Shortness of breath ☐Pain with deep inhalation ☐Frequent chest colds
☐Production or phlegm
Any other respiratory problems?_____

Gastrointestinal:
☐Nausea ☐Rectal pain ☐Crohn's disease
☐Vomiting ☐Indigestion ☐Irritable bowel syndrome
☐Diarrhea ☐Hemorrhoids ☐Diverticulosis
☐Constipation ☐Belching ☐Gallbladder trouble
☐Blood in stool ☐Ulcers ☐Jaundice
☐Black stool ☐Hiatal hernia ☐Liver disease
☐Abdominal pain or cramps ☐Heartburn/acid reflux
☐Gas/bloating ☐Colitis
Any other GI problems?_____

Urinary:
☐Pain on urination ☐Frequent urination ☐Kidney stones
☐Urgency to urinate ☐Blood in urine ☐Waking at night to urinate
☐Decrease in flow ☐Difficulty urinating
Any other urinary or kidney problems?
_____

Male:
☐Penile pain ☐Impotence ☐Sexually active?
☐Scrotal pain or inflammation ☐Penile discharge ☐Sexually transmitted infections
☐Erectile difficulty ☐Hernia
Any other issues?_____

Female:
☐PMS symptoms (physical/ emotional) ☐Excessive menstrual flow ☐Hysterectomy
☐Lumps in breast ☐Irregular cycle ☐Fibroids
☐Pelvic pain ☐Infertility ☐Sexually active?
☐Menstrual pain ☐Hot flashes ☐Sexually transmitted infections
☐Menopausal symptoms

Reproductive history:
☐Age of first menses:____
☐Menopause: Age_____
☐Number of total pregnancies if applicable:_____
☐Termination of pregnancy: (Y/N) #_____
☐Miscarriages: #_____

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☐Type of birth control if applicable, and for how long?_____
☐Number of live births: #____
☐Date of first day of last period:_____
☐Are you currently pregnant? (Y/N)
Any other issues?_____

Musculoskeletal:

☐Neck pain
☐Shoulder pain
☐Upper back pain
☐Lower back pain
☐General muscle pain
☐Muscle weakness
☐Hand/wrist pain
☐Knee pain
☐Hip pain
☐Foot/ankle pain
☐Numbness
☐Fractures
☐Joint stiffness
☐Arthritis
☐Difficulty standing or sitting
☐Disc problems

Any other musculoskeletal issues?_____

Neurological & Psychological:

☐Seizures
☐Loss of balance/coordination
☐Short temper
☐Anxiousness
☐Depressed mood
☐Poor memory
☐Overwhelmed by stress
☐Mood swings
☐Slurred speech
☐Compulsive behaviors
☐Numbness/tingling

Have you ever considered or attempted suicide?_____

Have you ever received professional support for your emotional wellbeing?_____

Any other neurological or psychological problems?_____

Do you have a history of trauma or abuse?_____

Self & Family Medical History

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition (maternal grandmother = MGM, maternal grandfather = MGF, paternal grandmother = PGM, paternal grandfather = PGF).

	Self	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF	Child	Other
Age (if living)											
Age (at death)											
Cause of death											
Allergies											
Alzheimer's or other dementia											
Anemia											
Anxiety											
Arthritis											

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	Self	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF	Child	Other
Asthma											
Autoimmune disease											
Bipolar disorder											
Cancer											
Cataracts											
Clotting disorder											
COPD or Emphysema											
Depresssion											
Diabetes											
GERD/Reflux											
Glaucoma											
Heart attack											
Other heart disease											
HIV/AIDS											
High blood pressure											
Irritable bowel syndrome											
Kidney disease											
Liver diease											
Meningitis											
Mental Illness											
Nerve/muscle disease											
Osteoporosis											
Parkinson's disease											
Seizures											
Stroke											

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	Self	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF	Child	Other
Substance abuse											
Thyroid disease											
Tuberculosis											
Ulcers											
Other											
Other											

Lifestyle

Movement & Nutrition:

Do you have an exercise or movement routine? If yes, describe:_____

_____

How many days/week? _____

Smoker? (Circle one) Current // Never // Occasional // Former

If current, former, or occasional smoker how many years and cigarettes/day?_____

If former smoker, when did you quit?_____

Recreational drug use?_____

Please check all that apply:

□Coffee Cups/day:_____

□Caffeinated tea: Cups/day:_____

□Alcohol Drinks/week:_____ Type:_____

□Soda: # per day:_____

□Water Glasses/day:_____

Do you eat regularly throughout the day?_____

Typical breakfast(s):_____

Typical lunch(s):_____

Typical dinner(s):_____

Snacks:_____

Do you have any food preferences or cravings? (i.e. salty foods, pizza, sweets, etc) _____

_____

Are there any foods you strongly dislike?_____

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Do you have any food allergies, intolerances, or sensitivities? _____

Sleep:

Do you have trouble falling asleep?_____

Do you have trouble staying asleep?_____ If so, are you able to fall back asleep?_____

Do you wake up feeling refreshed in the morning?_____

How many hours of sleep do you get each week night?_____ On weekends?_____

What time do you go to bed?_____ What time do you wake up?_____

How long does it typically take you to fall asleep?_____

Do you sleep with windows open or closed? _____

What is your preferred position to sleep in? (i.e. on right side, on back, etc)_____

What time of day do you feel most awake? _____ Most tired?_____

Stress:

What are your current triggers for stress?_____

_____

What things do you do to help soothe yourself during a stressful time?_____

_____

Do you feel you have good social support?_____

Have you ever utilized any of the following? (Check all that apply)

☐Acupuncture
☐Naturopathic medicine
☐Meditation
☐Biofeedback
☐Neurofeedback
☐Chiropractic
☐Massage
☐Counseling
☐Yoga
☐Other movement therapy

Have any of these been helpful to you? If yes, which ones?_____

_____

Is there anything else you would like me to know about you?_____

_____

_____

_____