

SATTVA HEALING ARTS

4110 Stone Way N
Seattle, WA 98103
202-425-4256
sattvahealingarts.com

Daphne Aberle, BSN, RN, LMP, ABT

(Please PRINT)

Name: _____ Birth date: _____ Age: _____

Home phone #: _____ Cell/Day #: _____

Address: _____

Emergency Contact: _____ Contact # _____

Gender: _____ Occupation: _____

Referred by: _____

Present Symptoms (your major complaint): _____

When did you first notice your present symptoms? _____

What brought on the issue? _____

What makes the issue worse? _____

What brings the issue relief? _____

Have you received a medical diagnosis for the issue? _____

Diagnosis (if applicable): _____

Name of diagnosing practitioner: _____

Other areas of difficulty (minor complaint): _____

Have you had any of the major or minor complaints before? _____

Medications (please list any prescription medications; over-the-counter medications; supplements; herbs):

Do you have any medication allergies? (Please list): _____

Please list any past operations: _____

Please list any accident history (e.g. fall; auto): _____

Have you broken any bones? _____

How much water do you typically drink in a day? _____

Frequency of bowel movements? _____

Please answer yes/no, and describe quantity/frequency as appropriate:

Smoking? _____

Caffeine? _____

Alcohol? _____

Recreational Drugs? (incl. type) _____

Birth Control? (incl. type) _____

Do you have any of the following issues?

(Please **CIRCLE** all that apply **currently** and **UNDERLINE** any **PAST** issue)

- | | | | |
|--------------------|--------------------|-------------------|-----------------|
| Headaches | Fainting | Back pain: | Bowel |
| Migraines | Vertigo/balance | Low back pain | incontinence |
| Sinus problems | issue | Mid-back pain | Ulcers |
| Seasonal allergies | Tinnitus (ears | Shoulder pain | Heartburn |
| Asthma | ringing) | Neck pain | Reflux |
| Loss of smell | Memory loss | Muscle spasms | Indigestion |
| Loss of taste | Heart pain | Nerve sensitivity | Gas |
| Weak vision / | Heart attack | Slipped disc | Gall Bladder |
| Glasses | Heart palpitations | Herniated disc | trouble |
| Light sensitivity | High blood | | Liver trouble |
| Cataracts | pressure | Arthritis | Kidney trouble |
| | Low blood | Painful joints | Urinary |
| Fatigue | pressure | Swollen joints | incontinence |
| Depression | Rheumatic fever | Swelling in legs | |
| Anxiety | Anemia | Cold feet | Hepatitis |
| Nervousness | | Cold hands | Diabetes |
| Feeling of stress | Shortness of | | Obesity |
| Tightness in | breath | Stomach trouble | Anorexia |
| throat | Tuberculosis | Irritable bowel | Eating disorder |
| Bipolar Disorder | COPD | (IBS) | Thyroid trouble |
| Anger/Irritability | Emphysema | Nervous stomach | Cancer |
| Insomnia | | Constipation | HIV/AIDS |
| Dizziness | | | |

Men only:

- Prostate trouble
- Difficult urination
 - Frequency
 - Burning
 - Difficult initiation
- Decreased libido
- Erectile dysfunction

Women only:

- Premenstrual trouble
- Menstrual cramps
- Heavy menstruation
- Scant/absent menstruation
- Irregular periods
- Vaginal discharge
- Breast tenderness
- Breast Implants
- Hot flashes
- Hysterectomy
- Pregnancy (#_____) Birth (#_____)

Please list any other condition of which you are aware: _____

Patient Signature: 	Date:
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