

**OpenMind Medicine
Krista Tricarico, ND**

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone(s) _____ Email address _____

Gender _____ Relationship Status _____

Household Members Include _____

Immediate Family Includes _____

Emergency Contact _____ Phone _____

Whom may I thank for this referral? _____

Current Health Care Team

Your Primary Care Doctor _____ Phone _____

Other Provider _____ Phone _____

Your Current Health

What are your main reasons for coming in today?

What kind of physical or mental health treatment have you received lately and from whom?

Please list any medications, vitamins, herbs or supplements you are taking:

Have you had a bad reaction to any medications/supplements? ___ Yes ___ No

If yes, please specify _____

Medical History

What childhood illnesses have you had? _____

What adult illnesses have you had? _____

Previous surgeries and hospitalizations: _____

Do you have any known allergies? _____

Personal Habits

What are your main interests/hobbies? _____

What work/study do you do? _____

Do you enjoy your work/school? _____

Do you drink alcoholic beverages? _____ If yes, how many per week? _____

Do you drink caffeinated beverages? _____ If yes, how many per week? _____

Do you smoke? _____ Use recreational drugs? _____

Have you struggled with addiction? _____ If yes, please explain. _____

How often and what type of exercise do you do? _____

Do you have a religious or spiritual practice? _____

Does your work or hobbies expose you to toxic chemicals, heavy metals, mold or

second hand smoke? _____

Sleep

On a scale of 1-10 (10 being great), how do you rate the your sleep quality? _____

Do you have problems falling or staying asleep? _____

How many hours do you sleep at night? _____ Do you awaken refreshed? _____

Energy

On a scale of 1-10 (10 being great), how do you rate your energy? _____

Are your daily tasks affected by your being tired? _____

Mood

On a scale of 1-10 (10 being great), how do you rate your mood? _____

Are your daily tasks affected by your mood? _____

What outside factors tend to influence your mood the most? _____

Stress

What are the major stressors in your life? _____

What techniques do you use to cope with your stress? _____

Diet

Do you follow a special diet? _____

How much water do you drink daily? _____

Please list the foods you've eaten and your meal times for the past 24 hours.

Is this a typical day for you? _____

Menstrual History (if applicable)

Do you currently have menstrual cycles? _____ If yes, length of cycle? _____

How many pregnancies have you had? _____ How many live births? _____

Health Concerns

Below is a list of health concerns. Please circle items that are current or recent problems for you and elaborate where necessary.

General: night sweats, fatigue/tiredness, weight problems, appetite changes, fever, temperature regulation, other

Skin: rash, infection, growths/bumps, nail problems, thinning/sensitive skin, other

Head: frequent headaches, migraines, head injury, light-headedness, hair loss/thinning, other

Eyes: vision problems, eye pain, double vision, itchy/watery eyes, other

Ears: hearing loss, ringing, earache, dizziness, itchy ears, hearing aids, other

Nose/Sinus: frequent colds, nose bleeds, sinus infections, hay fever/allergies, loss of smell, snoring, other

Mouth/Throat/Neck: frequent sore throat/hoarseness, sore tongue, mouth sores, phlegm, swollen glands, enlarged thyroid, trouble swallowing, neck pain, other

Respiratory: cough, sputum, wheezing, chest pain, shortness of breath, other

Heart/Circulatory: chest pain or discomfort, high blood pressure, heart murmur, palpitations, ankle swelling, dizziness, varicose veins, cold extremities, other

Digestion: heartburn, abdominal pain, nausea/vomiting, black tarry stools, abdominal bloating, belching/gas, hemorrhoids, constipation, diarrhea, other

Musculoskeletal: joint pain/stiffness, muscle cramps/spasms, weakness, other

Urinary/Male Reproduction: pain with urination, urgency/frequency, incontinence, frequent bladder infections, erectile difficulties, blood in urine, genital sores/discharge, other

Female Reproduction: excessive menstrual bleeding/pain/clots, irregular bleeding, vaginal discharge/itching/sores, painful intercourse, breast pain/lumps, nipple discharge, recurrent yeast infections, lack of sex drive, PMS, bloating, irritability, tearfulness, hot flashes, vaginal dryness, other

Mental/Emotional: depression, anxiety, mood swings, nervousness, tension, phobias, suicidal thoughts, alcohol/drug dependency, obsessive thoughts, hallucinations, voices, lack of mental focus, negative self-talk, other

Endocrine: thyroid problems, diabetes, blood sugar problems, excessive thirst or hunger, weight gain, weight loss, sugar cravings, abnormal hair growth, difficulty perspiring, excessive perspiration, temperature regulation problems, other
