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 _____

OpenMind Medicine
1016 SE 12th Ave Portland, OR 97214
503.593.8900

Name _____

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 your sleep quality? _____

Do you have problems falling or staying asleep? _____

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

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

Are your daily tasks affected by 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? _____

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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, compulsive behavior, addictions, 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