Five Seasons Health™

Welcome,

Thank you for making an appointment with us and taking an active part in the "Fifth Season," *your health*. We wanted to take a moment to inform you about us and our services. We are Primary Care Physicians, we treat the entire family for various issues. Here are a few conditions we treat for your consideration:

- Joint, spinal and scar pain
- Acute and chronic illnesses
- Auto immune disease
- Gastrointestinal issues
- Environmental/Heavy Metal toxicity
- Hormone imbalance

A few therapies we utilize include:

- Prolozone, Platelet Rich Plasma and Stem Cell injections
- IV nutrients
- Ozone therapies
- Chelation/Detoxification
- Nutrient, botanical/herbal and homeopathic medicines
- Anti-aging/bio-identical hormone replacement

Although our practice approach draws on naturopathic/wholistic philosophies we also prescribe medication when necessary. We look forward to serving you, your family and friends.

Thank you,

Dr. Robert Ellsworth and Dr. Jeffrey A. Lee
Five Seasons Health

Five Seasons Health™

NEW PATIENT INTAKE

Date _____

Name _____ Birth Date _____
Address _____ Home # _____
City _____ State _____ Zip_____ Cell # _____
Email _____@_____ Work # _____
Which phone number is the best to reach you: _____
Occupation: _____ Height: _____ Weight: _____ Age: _____
Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Name of spouse/significant other _____
# of Children: _____ # at home: _____ Children's Names: _____
_____
Parent/Guardian (if patient is a minor): _____
Emergency contact name: _____ Relationship: _____
Contact #: _____
How did you find us: _____ Referred by: _____
Please list your health concerns:
1._____
2._____
3._____
4._____

Please list your other health professionals (they will not be contacted without your consent)			
Name	Specialty	Office Location	Telephone

MEDICAL HISTORY

Drug allergies: _____
Food or other known allergies: _____
Have you ever been tested for food allergies: ☐ Yes ☐ No
If yes, how were you tested: _____
List any food cravings: _____
Are you sensitive to chemicals, smells or odors: ☐ Yes ☐ No
If yes, which _____
Are you frequently thirsty: ☐ Yes ☐ No

Personal and Family Health History						
Disease	Self	Mother/ Father	Brother/ Sister	Child	Aunt/Uncle	Grandparent Maternal/Paternal
Alcohol/Drug Abuse						
Allergies/Sinus						
Alzheimers						
Arthritis						
Birth Defect						
Cancer/Type						
Diabetes						
Depression/Anxiety						
Emotional Disorder						
High cholesterol/Fat						
Heart Disease						
High Blood Pressure						
Obesity						
Thyroid Disorder						
Stroke						
Other:						

Rate the quality of your sleep (1 low - 10 high): _____ How many hours do you sleep: _____

Energy Level: Rate your energy level (1 low –10 high): _____

Digestive Function: ☐ Diarrhea ☐ Constipation ☐ Gas ☐ Bloating ☐ Move Bowels Daily

How many 8 oz glasses of water do you drink daily: _____ Other beverages: _____

Alcohol use: ☐ Yes ☐ No If yes, which types: _____

How often: _____

Caffeine use: ☐ Yes ☐ No If yes, which sources: _____

How often: _____

Soda/candy/sugar use ☐ Yes ☐ No If yes, which kind: _____

How often: _____

Do you consume artificial sweeteners: ☐ Yes ☐ No If yes, which ones: _____

Do you consume diet drinks: ☐ Yes ☐ No

Tobacco use: ☐ Yes ☐ No Types: _____ Daily dosage: _____

Years of use: _____

Do you use recreational/illegal drugs: ☐ Yes ☐ No If yes, which: _____

Any sexual difficulties you would like to speak about: ☐ Yes ☐ No

If yes, please describe: _____

Do you exercise: ☐ Yes ☐ No Types:_____ How often: _____

How many times a week do you eat in restaurants: _____ Do you eat *fast food*: ☐ Yes ☐ No

Any weight issues: _____ Current Weight: _____ Highest lifetime weight: _____

How many hours do you work each week: _____

Do you engage in meditation or prayer ☐ Yes ☐ No

Rate your average stress level (1 low -10 high): _____

Describe your current stressors: _____

Have you ever been exposed to mold: ☐ Yes ☐ No

Have you ever been exposed to solvents, chemicals or pesticides: ☐ Yes ☐ No

If yes, which: _____

Previous dental procedures: ☐ Extraction(s) ☐ Filling(s) ☐ Root canal(s) ☐ Crown(s) ☐ Bridge(s)

Other: _____

To what extent are you open to changes in lifestyle and diet: ☐ Eager ☐ Receptive ☐ Resistant

Date (Month/Year) of last medical exam: _____ Blood Type: _____

Approximate date of your last blood tests: _____

Describe any abnormal labs, imaging or other tests you have received in the past :_____

_____

FOR WOMEN ONLY

Date of last pap: _____ results were: ☐ Normal ☐ Abnormal

Date of last mammogram: _____ results were: ☐ Normal ☐ Abnormal

Date of last thermography: _____ results were: ☐ Normal ☐ Abnormal

Start date of your last menstrual cycle: _____

How would describe menses: ☐ Regular ☐ Irregular ☐ Light ☐ Heavy ☐ Short ☐ Long

☐ Frequent ☐ Intermittent ☐ Painful

Other significant female related history :_____

_____

_____

MEDICATION/SUPPLEMENTATION

Please list all current prescription medications					
Medication/ Supplements	Dosage	For what purpose?	How long have You taken it?	Prescribed by: Dr's name or self	Side Effects

DIET

Please describe your typical diet	
Breakfast	
Mid-morning snack	
Lunch	
Mid-afternoon snack	
Supper	
Evening snack	
Other	

Your Wellness Biography

The top is your birth, the bottom is the present. On the left, please mark major health events such as surgeries, hospitalizations, accidents/injuries, illnesses, etc. On the right, please mark major social events such as marriages, childbirths, relocations, occupational changes, educational milestones, etc. Include the age you experienced each event.

Health Biography
Injury, illness, surgery,
auto accidents,
times of best health, etc.

Social Biography
Stress, best times, graduations,
marriage, divorce, births, deaths,
moves, job changes, etc.

BIRTH

PRESENT

PERSONAL HEALTH ASSESSMENT
Rate each of the following symptoms upon your typical health profile over the last year.

Point Scale
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

	Energy/Activity
	Fatigue, sluggishness
	Apathy, lethargy
	Hyperactivity
	Restlessness
	Easy fatiguability or lack of endurance
	Headaches
	Faintness
	Dizziness
	Insomnia
	Subtotal

	Emotional/Mental
	Mood swings
	Anxiety, fear or nervousness
	Anger or irritability
	Depression
	Poor memory
	Confusion, poor comprehension
	Poor concentration
	Difficulty in making dececisions
	Stuttering or stammering
	Slurred speech
	Learning disabilities
	Subtotal

	Joints/Muscles/Skin
	Pain or aches in joints
	Stiffness or limitation of movement
	Pain or aches in muscles
	Feeling of weakness or tiredness
	Cramps in legs
	Acne
	Hives, rashes or dry skin
	Hair loss
	Flushing or hot flashes
	Fingernail abnormalities (spots, ridges)
	Decreased sweating
	Night sweats
	Subtotal

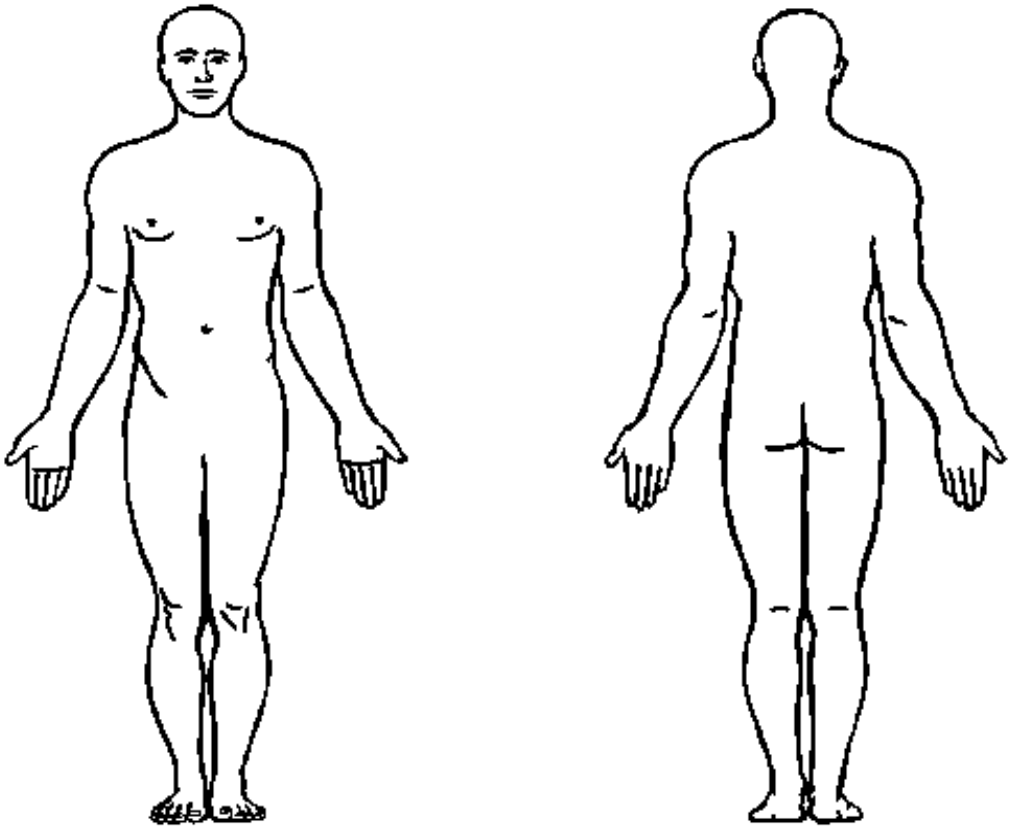
	Ears/Mouth/Throat/Nose/Eyes
	Itchy ears
	Earaches, ear infections
	Ringing in ears, hearing loss
	Drainage from ear
	Stuffy nose
	Sinus problems
	Hay fever
	Excessive mucous formation, post-nasal drip
	Sneezing attacks
	Poor night vision
	Watery or itchy eyes
	Swollen, tender or sticky eyelids
	Bags or dark circles under eyes
	Blurred or tunnel vision (excluding near/far sightedness)
	Chronic coughing
	Sore throat, hoarseness, loss of voice
	Swollen or discolored tongue, gums, lips
	Canker sores
	Subtotal

	Digestive Tract
	Nausea or vomiting
	Diarrhea
	Constipation
	Bloated feeling
	Belching or passing gas
	Heartburn
	Subtotal

	Heart/Lungs
	Irregular or skipped heartbeat
	Rapid or pounding heartbeat
	Chest pain
	Chest congestion
	Asthma, bronchitis
	Shortness of breath
	Subtotal

	Weight/Other
	Binge eating/drinking
	Craving certain foods
	Excessive weight
	Compulsive eating
	Water retention
	Underweight
	Frequent illness
	Frequent or urgent urination
	Genital itch or dicharge
	Injury
	Subtotal
	TOTAL POINTS

Please circle any areas you have pain or other symptoms and describe any details.
Please mark with an “X” where you have scars.



Patient’s or Guardian’s signature

Date