MAUI REGENERATIVE MEDICINE

2310 Umi Place Haiku Hawaii 96708
Office: 808-575-2328
www.mauiregenerativemedicine.com

Patient History Information

Name		Date	
Address		State/Zipcode	
Phone Home	Cell	SSN#	
Age	Date of Birth	Sex	M F
Occupation		Employer	
Marital Status: S M W D	No. of Children:	Spouse Name	
Emergency Contact Name and Phone			
Email			
How did you find out about our office?			
How do you prefer we contact you:			
What is the reason for this visit?			

Is this condition due to: Auto accident Work Injury Other accident Illness Other

Are symptoms: Improving Getting worse About the same Intermittent

Date symptoms appeared: Have you ever had these symptoms before? Yes No

Have you seen any of the following doctors for this? MD Naturopathic Dr

Chiropractor Acupuncturist Other:

Therapy Received: Dates treated:

Diagnosis:

Reason for termination of treatment:

Medications Prescribed:

Doctors Name:

I understand that a 24 hour advance notification is required for scheduling or cancelling of appointments to avoid a charge. I understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patients Signature: Date

Health History *(continued)*

Typical example of:
Breakfast _____
_____
Lunch _____
_____
Supper _____
_____

Have you been observing any special dietary restrictions? _____
_____
_____

Exercise habits
(list kind of exercise, frequency - times per week & duration - minutes per day):
_____
_____
_____
_____
How many years have you had a regular exercise program? _____

Bowel habits:
☐ regular ☐ irregular
(please mark "f"=frequently, "oc"=occasionally)
Have you experienced:
☐ constipation _____
☐ diarrhea _____
☐ mucous on stool _____
☐ blood on stool _____
☐ undigested food _____

Energy level:
☐ good
☐ drops in the afternoon
☐ low upon waking
☐ drops unpredictably
☐ low after eating

Sleep habits:
☐ sleep well, wake rested
☐ wake _____ times in the night at _____am/pm
☐ difficulty falling asleep
☐ dreams
☐ nightmares
☐ wake tired

Urination: _____times/day wake _____times/night

Appetite:
☐ good ☐ poor
Food cravings for _____
Preferred flavor (circle): *salty, spicy, sour, sweet, bitter*
Diet:
☐ 3 meals/day ☐ small fequent meals
☐ Eat at restaurant _____ times/week
Digestion:
☐ Frequent bloating ☐ belching
☐ nausea ☐ Stomach rumbles
Intolerant of:
☐ fats & oils ☐ raw vegetables
☐ sweets ☐ proteins

Pain:
☐ head ☐ neck ☐ shoulders
☐ mid back ☐ low back ☐ extremities
☐ chest ☐ stomach ☐ abdomen
☐ groin ☐ genitalia
Was this a result of an accident? _____ Explain: _____
_____
_____
Onset of symptoms: _____
Relieved by:
☐ hot ☐ cold ☐ pressure ☐ motion ☐ lying still
describe nature of pain _____
Exact location: _____
Type:
☐ sharp ☐dull ☐ throbbing ☐ constant
☐ tearing ☐ aching ☐ other _____

Dr. Kevin J. Davison, N.D., L.Ac. • Graduate: B.A., Pre-Med, Asian Studies, University of Hawaii; Pre-Med, University of California at Berkeley; L.Ac., Oregon College of Oriental Medicine; N.D., National College of Naturopathic Medicine; Member: American Association of Naturopathic Physicians; Physician, Wellness Director: IBM China Corporation

(Give approximate age when illness occurred.)

- ☐ chicken pox _____
- ☐ mumps _____
- ☐ orthopaedic problems _____
- ☐ measles _____
- ☐ herpes simplex _____
- ☐ mononucleosis _____
- ☐ parasites _____
- ☐ skin conditions _____
- ☐ known allergies:
  - ☐ foods _____
  - ☐ airborne _____
  - ☐ drugs _____
  - ☐ other _____
- ☐ asthma _____
- ☐ kidney disorders _____
- ☐ previous medications _____

Any unfavorable reaction? ☐ yes ☐ no
describe: _____
Any other childhood illness or injury?
(dates & description) _____

History of surgeries: _____

Recent health history:
(mark date of onset and a brief description)

- ☐ anemia _____
- ☐ arthritis/rheumatism _____
- ☐ bronchitis _____
- ☐ cancer _____
- ☐ chronic fatigue _____
- ☐ constipation _____
- ☐ diabetes _____
- ☐ digestive problems _____
- ☐ emotional instability _____
- ☐ headaches _____
- ☐ heart palpitations _____
- ☐ hepatitis/liver disease _____
- ☐ high blood pressure _____
- ☐ hypoglycemia (low blood sugar) _____
- ☐ long term flu _____
- ☐ menstrual problems _____
- ☐ multiple allergies _____
- ☐ shortness of breath _____
- ☐ spinal pain _____

Do you have a family history of any of the above? _____

Illness not mentioned? _____

If you've has a recurrance of a childhood or chronic illness, please give date of recurrance and brief description: _____

Give approximate frequency of use of the following:

- ☐ coffee _____ cups/day
- ☐ cigarettes _____ pks/day
- ☐ marijuana _____ times/week
- ☐ alcohol _____ times/week
- ☐ recreational drugs _____ times/week

Supplements:

- ☐ vitamins: _____ _____ times/day
  _____ _____ times/day
- ☐ enzymes: _____ _____ times/day
- ☐ minerals: _____ _____ times/day
- ☐ herbal treatments: _____ times/day
- ☐ Current prescription/ non-prescription medications: *(include doosage and duration of adminstration)* _____

- ☐ History of long-term antibiotic use: *(list type, date, and duration)* _____

- ☐ Urinary Tract Infections: *(list date and treatment)* _____

- ☐ History of travelers diarrehea or intestinal parasites: *(type of parasite, diagnosed by, symptoms & treatment)* _____

Dr. Kevin J. Dawson, N.D., L.Ac. • Graduate: B.A., Pre-Med, Asian Studies, University of Hawaii, Pre-Med, University of California at Berkeley, L.Ac., Oregon College of Oriental Medicine; N.D., National College of Naturopathic Medicine; Member: American Association of Naturopathic Physicians; Physician, Wellness Director, IBM China Corporation