# Diagram Description automatically generatedDr. Timothy R. Morris, ND, IFMCP

# Naturopathic Doctor & IFM Certified Practitioner

# PATIENT INFORMATION |*Please use MS WORD if possible to fill in the gray boxes, or print clearly. Do not “fix margins” when saving or printing.*

|  |  |
| --- | --- |
| Patient Name: |  |
| Date of Birth: |  |
| Marital Status: |  |
| Home Address: |  |
| City, State, Zip: |  |
| Cell Phone: |  |
| Home Phone: |  |
| E-mail: |  |
| Occupation: |  |
| Employer / School: |  |
| Work / School Phone: |  |
| Emergency Contact Person |  |
| Emergency Contact Phone |  |

**Primary HEALTH Care Provider or REFERRAL SOURCE**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Phone #: |  |
| Fax #: |  |

# RESPONSIBLE PARTY and/or SPOUSE’S INFORMATION

|  |  |
| --- | --- |
| Spouse or Responsible Party: | (if different than patient) |
| Case # / Date of Birth: | (if different than patient) |
| Address: | (if different than patient) |
| Phone: | (if different than patient) |
| Employer: | (if different than patient) |

# INSURANCE INFORMATION *(for lab billing only)*

|  |  |
| --- | --- |
| Insurance Company |  |
| Group |  |
| ID # |  |
| Address: |  |
| Phone Number: |  |

**Address: 7041 11th Ave NW Seattle, WA 98117 ~ Tel: 206-947-4915 ~ Fax: 206-274-4955 Email:** [**TR@trmorrisnd.com**](mailto:TR@trmorrisnd.com)

**Patient Intake Forms**

Please e-mail ([**tr@trmorrisnd.com**](mailto:tr@trmorrisnd.com)**),** fax **(206-274-4955**), or mail the forms to Dr. Morris prior to your initial visit.

**Current Age:       Male, Female, Non-Binary Height:** **Weight:**

**Married , Single , Separated/Divorced ; Children**  **Occupation:**

Top 3 HEALTH Concerns:   
Please list your primary health concerns in order of importance. Details will be gathered in the next three pages.



OPTIMAL HEALTH GOALS:   
Briefly describe what optimal health & function looks like for you.



WHAT DO YOU WANT YOUR HEATH FOR?   
Please name some purposes, aspirations, or activities that you want to accomplish



**READINESS FOR CHANGE**

**How willing you are to do the following to improve your health 0-5? (5=very willing, 0=not willing)**

1. Be educated on the causes of your health or disease
2. Engage in regular exercise
3. Significantly modify your diet
4. Modify your lifestyle (work demands, hours of sleep, avoiding stressors, etc.)
5. Reduce your intake of caffeine, alcohol, tobacco, recreational drugs, and medications
6. Practice a relaxation technique (conscious breathing, meditation, yoga, etc.)
7. Take vitamins, minerals, herbal supplements, or hormonal support
8. Have periodic lab tests to assess your progress
9. Have regular follow up appointments to asses and update your treatment plan
10. Inform the doctor if a treatment suggestion is not likely to be used, or is not working

PATIENT PREFERENCE

Is there any particular approach or behavior that you especially want or appreciate (or don't want) from Dr. Morris?

**CURRENT concern #1**

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| **CONCERN #1** | Name the diagnosis, symptom or concern. |  |
| **LOCATION  & QUALITY** | If applicable, name the location and quality of the symptom (sharp, dull, constant, etc.). |  |
| **ONSET & CAUSES** | When did this start?  What triggered this?  “I’ve never been well since**\_\_\_**” |  |
| **SEVERITY** | Rate the intensity 0-10:  0 = perfect  10 = worst imaginable |  |
| **FREQUENCY & DURATION** | How frequently does it occur? How long does symptom last when it is present? |  |
| **TIMING** | Is the problem worse at any particular time (day/week/month/season)? |  |
| **TRIGGERS** | Is there anything in particular that triggers this issue? |  |
| **AGGRAVATING FACTORS** | What treatments, activities, foods, settings, etc. make the problem WORSE? |  |
| **RELIEVING FACTORS** | What treatments, activities, foods, settings, etc. make this issue BETTER? |  |
| **ASSOCIATED SYMPTOMS** | Are there other symptoms that come on with or after this? |  |
| **PROGRESSION** | Is the problem generally getting worse, better, or not changing? |  |
| **FAMILY HISTORY** | Has a family member had a similar concern in the past? |  |
| **YOUR OPINION** | What do you think is causing and/or perpetuating this problem? |  |
| **ADDITIONAL INFORMATION** | What else is important to fully understand your concern |  |

**CuRRENT concern #2**

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| **CONCERN #2** | Name the diagnosis, symptom or concern. |  |
| **LOCATION  & QUALITY** | If applicable, name the location and quality of the symptom (sharp, dull, constant, etc.). |  |
| **ONSET & CAUSES** | When did this start?  What triggered this?  “I’ve never been well since\_\_\_” |  |
| **SEVERITY** | Rate the intensity 0-10:  0 = perfect  10 = worst imaginable |  |
| **FREQUENCY & DURATION** | How frequently does it occur? How long does symptom last when it is present? |  |
| **TIMING** | Is the problem worse at any particular time (day/week/month/season)? |  |
| **TRIGGERS** | Is there anything in particular that triggers this issue? |  |
| **AGGRAVATING FACTORS** | What treatments, activities, foods, settings, etc. make the problem WORSE? |  |
| **RELIEVING FACTORS** | What treatments, activities, foods, settings, etc. make this issue BETTER? |  |
| **ASSOCIATED SYMPTOMS** | Are there other symptoms that come on with or after this? |  |
| **PROGRESSION** | Is the problem generally getting worse, better, or not changing? |  |
| **FAMILY HISTORY** | Has a family member had a similar concern in the past? |  |
| **YOUR OPINION** | What do you think is causing and/or perpetuating this problem? |  |
| **ADDITIONAL INFORMATION** | What else is important to fully understand your concern? |  |

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| **CONCERN #3** | Name the diagnosis, symptom or concern. |  |
| **LOCATION  & QUALITY** | If applicable, name the location and quality of the symptom (sharp, dull, constant, etc.). |  |
| **ONSET & CAUSES** | When did this start?  What triggered this?  “I’ve never been well since\_\_\_” |  |
| **SEVERITY** | Rate the intensity 0-10:  0 = perfect  10 = worst imaginable |  |
| **FREQUENCY & DURATION** | How frequently does it occur? How long does symptom last when it is present? |  |
| **TIMING** | Is the problem worse at any particular time (day/week/month/season)? |  |
| **TRIGGERS** | Is there anything in particular that triggers this issue? |  |
| **AGGRAVATING FACTORS** | What treatments, activities, foods, settings, etc. make the problem WORSE? |  |
| **RELIEVING FACTORS** | What treatments, activities, foods, settings, etc. make this issue BETTER? |  |
| **ASSOCIATED SYMPTOMS** | Are there other symptoms that come on with or after this? |  |
| **PROGRESSION** | Is the problem generally getting worse, better, or not changing? |  |
| **FAMILY HISTORY** | Has a family member had a similar concern in the past? |  |
| **YOUR OPINION** | What do you think is causing and/or perpetuating this problem? |  |
| **ADDITIONAL INFORMATION** | What else is important to fully understand your concern? |  |

**CURRENT concern #3**

**Review of SysteMs**

**Please check the boxes that apply and explain the problem areas further at the bottom of each section. No additional explanation is necessary here if the problem was one of the 3 major heath concerns detailed earlier.**

# General

Fatigue (feeling tired or worn out)

Unexpected weight gain  
 Unexpected weight loss

Poor appetite

Increased appetite

Excessive sleeping

Difficulty sleeping

Unusual sensitivity to cold  
 Unusual sensitivity to heat

Hot or cold spells

Sweating excessively at night

Excessive daytime sweating

Lowered resistance to infection

Flu-like or vague sick feeling

Excessive thirst

Other:

Details:

# Neurological

Problems with memory

Problems with concentration

Depressed or hopeless mood

Suicidal thoughts or planning

Excess worrying, anxiety

Panic attacks

Forgotten periods of time

Dizziness

Drowsiness

Tremors (in hands or feet. etc.)

Twitching, spasms or “tics”

Numbness / Tingling

Convulsions / fits

Slurred speech

Speech problem (other)

Weakness in muscles

Other:

Details:

# Respiratory

Shortness of breath

Asthma, wheezing

Chronic cough

Coughing up blood or sputum

Rapid breathing

Repeated sinus infections

Repeated bronchitis/pneumonia

Other:

Details:

### Chest & Cardiovascular

Chest pain

Palpitations/arrhythmias

Rapid / irregular pulse   
 Ankle swelling/edema

High blood pressure

Low blood pressure

Other:

Details:

**Head, Eye, Ear, Nose, & Throat**

Frequent sore throats

Post-nasal drip

Disturbances in smell

Runny nose or dry nose

Repeated ear infections

Hearing loss in one or both ears

Ringing in ears / tinitus

Headache

Head injury

Facial pain

Blurry/Double vision

Overly sensitive to light

Dry mouth

Trouble swallowing

Other:

Details:

### Gastrointestinal & Hepatic

Constipation

Loose/liquid bowel movements

>3 Bowel movements/day

<7 Bowel movements/week

Abdominal (stomach/belly) pain

Abdominal swelling/bloating

Slow digestion

Nausea or vomiting

Loss of bowel control

Painful bowel movements

Frequent belching (burps)

Frequent flatulence (farting)

Jaundice (yellowing of skin, eyes)

Rectal bleeding (red or black blood)

Rectal itching

Other:

Details:

# Musculoskeletal

Neck pain or stiffness

Back pain or stiffness

Joint pain or stiffness

Bone pain

Leg pain

Muscle cramps, spasm, or pain

Muscle twitching

Weakness/Other:

Details:

### Skin, Hair, Nails

Dry hair or skin

Itchy skin or scalp

Rash/Hives

Acne

Easy bruising

Excessive hair loss

Excess hair growth

Increased perspiration

No perspiration

Brittle Nails

Nails with spots/lines

Other

Details:

### Genitourinary

Itchy privates or genitals

Painful urination

Excessive urination

Difficulty starting urination

Accidental wetting of self

Pus or blood in urine

Decreased sexual desire

Other:

Details:

# Females

No menses

Menstrual irregularity

Premenstrual Concerns:

cramps

headaches

sadness/moodiness

irritability/anger

water retention/bloating

breast tenderness

Heavy menstrual periods

Painful menstrual periods

Abnormal vaginal discharge

# Pain during sex

# Sterility or fertility issues

Problems with pregnancies

Pregnancies

Deliveries

Miscarriages

Other:

Details:

# Males

Impotence (weak male erection)

Inability to ejaculate or orgasm

Scrotal pain

Mass on testicles

Mass in scrotum

Decreased/absent ability to urinate

Waking up at night to urinate

Unable to stop urination

Abnormal penile discharge

Other:

Details:

# Miscellaneous/Other

Health concerns/symptoms not listed above or detailed in the top 3 concerns:

**PErSONAL & FAMILY MEDICAL HISTORY**

**In the table below, please indicate the medical conditions you and your family members have had.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **HEALTH CONDITION** | **Self *(current)*** | **Self**  ***(Past)*** | Relative | **DETAILS (who, onset, severity, treatment, resolution, etc.)** |
| Suicidal Thoughts/Intent |  |  |  |  |
| Blood Pressure |  |  |  |  |
| High Cholesterol/Lipids |  |  |  |  |
| Diabetes/High Blood Sugar |  |  |  |  |
| Low Blood Sugar |  |  |  |  |
| Obesity/Overweight |  |  |  |  |
| Fatigue/Chronic Fatigue |  |  |  |  |
| Heart Murmur/Arrhythmia |  |  |  |  |
| Blood Clots/Stroke |  |  |  |  |
| Heart Attack/Coronary Dis. |  |  |  |  |
| Sleep Apnea/Sleep Disorder |  |  |  |  |
| Asthma/COPD/Pneumonia |  |  |  |  |
| Allergies/Hay Fever |  |  |  |  |
| Frequent Sinus/Ear Infection |  |  |  |  |
| Food Allergies/Sensitivities |  |  |  |  |
| Skin Conditions |  |  |  |  |
| Indigestion/Heartburn/GERD |  |  |  |  |
| Ulcers (Gastrointestinal) |  |  |  |  |
| Liver/Gall-Bladder Disease |  |  |  |  |
| Colitis/Cohn’s Disease/UC |  |  |  |  |
| Irritable Bowel (IBS) |  |  |  |  |
| Thyroid Conditions (high/low) |  |  |  |  |
| Adrenal Dysfunction |  |  |  |  |
| Chronic Neck/Back Pain |  |  |  |  |
| Osteopenia/Osteoporosis |  |  |  |  |
| Osteoarthritis (joint pain) |  |  |  |  |
| Rheumatoid Arthritis |  |  |  |  |
| Autoimmune: Lupus, MS, etc. |  |  |  |  |
| Kidney/Urinary Disease |  |  |  |  |
| Abuse: Physical/Sexual |  |  |  |  |
| Anxiety/Depression |  |  |  |  |
| Attention Deficit/ADD |  |  |  |  |
| Anorexia/Bulimia/Binging |  |  |  |  |
| Alcohol/Drug Misuse |  |  |  |  |
| Mental Illness |  |  |  |  |
| Headaches/Migraines |  |  |  |  |
| Seizures |  |  |  |  |
| Alzheimer’s Disease |  |  |  |  |
| Parkinson’s Disease |  |  |  |  |
| Cognitive Impairment/Decline |  |  |  |  |
| Cancer(s) |  |  |  |  |
| Other: |  |  |  |  |

**PAST MEDICAL CARE**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **DRUG ALLERGIES** | List all known and suspected allergies to medications |  |
| **ENVIRONMENTAL ALLERGIES** | List all known and suspected allergies: pollen, pets, mold, etc. |  |
| **FOOD ALLERGIES & SENSITIVITIES** | List all known and suspected Food allergies/sensitivities/intolerance. |  |
| **HOSPITALIZATIONS** | What were you hospitalized for? When? What treatments were given? |  |
| **SURGERIES** | Name the surgeries, what was treated, when, and the outcomes. |  |
| **VACCINATIONS** | Conventional or alternate schedule? Optional vaccinations (shingles, flu, HPV, etc.)? Unusual reactions? |  |
| **DENTAL CARE** | Date of last dental checkup, X-rays. |  |
| **DENTAL ISSUES** | Significant past issues: cavities, fillings/root canals (type), extractions/implants, gum or bone issues, etc. |  |
| **WORK RELATED ILLNESSES** | Have you even been significantly injured or exposed to harmful environments at work? Describe. |  |
| **TRAVEL RELATED ILLNESSES** | e.g. Traveler’s Diarrhea, Malaria, Parasites, Dengue/Yellow Fever, meningitis, other. Indicate when. |  |
| **LAST PHYSICAL EXAM** | When? By whom? Significant indings? |  |
| **RECENT BLOOD OR LAB WORK** | Date? Ordered by? Details to be provided later. |  |
| **OTHER  CURRENT CARE** | Other providers currently seen. Name/Specialty? Last seen?  Conditions Treated. |  |
| **DISCONTINUED CARE** | Other providers seen in the past for your current concerns. Please indicate your reasons for stopping. |  |

**CHILDHOOD & ADULT HISTORY**

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| **PRENATAL DETAILS** | Your mother’s age, maternal health, substance use, diet, exposures, mental health, gestational stress level, etc. |  |
| **BIRTH DETAILS** | Full term or premature, vaginal or cesarean, hospital or home birth, respiratory disresss, other details… |  |
| **CHILDHOOD ILLNESSES** | e.g. Colic, chicken pox, measles, major allergies, ear infections, pneumonia, leukemia, etc. |  |
| **CHILDHOOD SETTINGS** | Locations, environments (urban, suburban, rural, agricultural, industrial), foreign travel, etc. |  |
| **SOCIAL FOUNDATION** | Single or dual parents, siblings, birth order, adoption, extended family contact, community, etc. |  |
| **CHILDHOOD SECURITY/STRESS** | Did you feel unsafe as a child?  Did you experience significant trauma, stress, or hardships? |  |
| **PAST RELIGIOUS OR SPIRITUAL PRACTICE** | Were you raised with a particular religious preference that you no longer practice? |  |
| **CURRENT SPIRITUAL PRACTICE** | Do you have a current religious or spiritual practice? If so please describe briefly. |  |
|  |  |  |
| **TRAVEL HISTORY** | Where have you traveled out of the country; when and for how long? Note any illnesses. |  |
| **OCCUPATIONAL HISTORY** | Summarize your employment history and the TYPES of jobs you’ve had. |  |
| **KNOWN TOXIC EXPOSURES** | Have you been exposed to significant industrial pollutants, hazardous waste, exhaust, mold, pesticides, mercury, lead, solvents, PCBs, PBDEs, etc. |  |
| **TOBACCO USE** | Please indicate past and present use |  |
| **RECREATIONAL DRUG USE** | Please indicate past and present use. (This may also be disclosed during the visit.) |  |
| **INJURIES &  TRAUMAS** | e.g. head injury, car accidents, falls, broken bones, major sprains. Indicate the date and treatments. |  |

**NUTRITION & LIFESTYLE FACTORS**

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| --- | --- | --- |
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| **DIETARY HABITS & RESTRICTIONS** | For example: vegetarian, gluten free, dairy free, Low FODMAP, AI-paleo, ketogenic, Zone, etc. |  |
| **TYPICAL BREAKFASTS** | Do you eat breakfast? If so what are some examples? |  |
| **TYPICAL LUNCHES** | Describe typical lunches. |  |
| **TYPICAL DINNERS** | Describe typical dinners. |  |
| **TYPICAL SNACKS** | Do you snack? How often?  Please give a few examples. |  |
| **HYDRATION** | How much water do you typically drink on a daily basis?  (coffee & alcohol don't count) |  |
|  |  |  |
| **CAFFEINE USE** | Include coffee, tea, soda and the amount per day, week or month. |  |
| **SWEET DRINKS** | Do you drink diet or regular soda, undiluted fruit juices, “desert” coffees (w/ flavored syrup), etc.? |  |
| **FAST FOOD & PASTRIES** | How often do you eat fast food, pastries, instant meals, (per day/week/month)? |  |
| **ALCOHOL USE** | Please indicate the amount per day, week, or month. Are you or loved ones concerned about you over-consuming alcohol? |  |
| **SLEEP BEHAVIOR** | Usual bedtime, onset time, duration, regularity, quality. Indicate and describe any snoring, apnea, sleepwalking, nightmares, difficulty falling/staying asleep, etc. |  |
| **RELAXATION & RECUPERATION** | What kinds of things do you do to unwind, relax and recharge? How often? Are these effective? |  |
| **CURRENT MAJOR LIFE STRESSORS** | List major stressors: work, school, finances, children, family, relationships, caregiving, illness, etc. |  |
| **EXERCISE & MOVEMENT** | Indicate frequency, intensity, type, and duration: (e.g. 3x/week, 30min, moderate, aerobic (or strength/resistance or flexibility) |  |
| **RELATIONSHIPS & NETWORKS** | Do you have people or groups with whom you feel seen, heard, accepted and supported? |  |

**TIMELINE of MOST SIGNIFICANT LIFE & Medical EVENTS**

**Chronologically list and describe your significant life and medical events. Indicate the EVENT TYPE and start date.**

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| --- | --- | --- | --- | --- |
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| **EVENT TITLE** | **EVENT TYPE** | **START DATE**  (Month &Year) | **END DATE**  (If applicable) | **EVENT DESCRIPTION** |
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| ADDITIONAL INFORMATION: | | | | |

**LAB TEST & IMAGING STUDIES**

* **Please locate significant past lab and imaging studies—and have them faxed, emailed, or mailed in.**
* **In the table below, please enter the most relevant results in chronological order (recent first).**

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| **LAB TESTS & IMMAGING STUDIES** | **DATE** (month & year) | **PRESCRIBING PROVIDER** | **FINDINGS** (normal or abnormal; include the numbers and the normal ranges) |
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| ADDITIONAL INFORMATION: | | | |

**MEDICATION & SUPPLEMENT HISTORY**

* **List medications, hormones & supplements you currently take—your current regimen.**
* **Include the symptom/diagnosis or reason you take/took the medication or supplement—and your response/reactions.**
* **Afterwards, list significant medications and supplements you took in the past—and your response/reactions.**
* **Please bring your current meds and supplements with you (or have them nearby for remote consults).**

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| **SUPPLEMENT OR MEDICATION** | **DOSAGE & FREQUENCY** | **START & END (month/year)** | **DIAGNOSIS OR REASON FOR TAKING.  INDICATE YOUR RESPONSE, SIDE EFFECTS** |
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| ADDITIONAL INFORMATION: | | | |

**By responding below, the patient/guardian indicates that the information given in these intake forms above is correct and complete to the best of their ability and agree that any problems that arise due to incomplete or incorrect information are the responsibility of the patient or guardian**.

Patient OR Guardian:       Date:

**MEDICAL RECORDS RELEASE**

(Patient Name)

(Address)

(Date of Birth)

HEREBY REQUESTS:

(Health care provider)

(Fax# / Address)

(Health care provider **#2—if needed**)

(Fax# / Address)

(Health care provider **#3—if needed**)

(Fax# / Address)

To release any and all information contained in my medical records to:

**Dr. Timothy R. Morris**

**7041 11th Ave NW, Seattle, WA 98117**

**Phone: 206-947-4915**

**Fax: 206-274-4955**

**Email:** [**TR@trmorrisnd.com**](mailto:TR@trmorrisnd.com)

I understand that this authorization (unless expressly limited by me in writing)   
extends to all aspects of my medical records including test results, imaging, prescriptions and past treatment recommendations and chart notes.

Patient Signature:       Date: