Yvonne Justine Kreger, ND, LLC
1820 SW Vermont St., Suite F
Portland, OR 97219
(503) 293-5000

New Patient Information

Name_____ Date _____
Age_____ Date of Birth _____ Gender: female_____ male _____
Address_____
City_____ State_____ Zip Code_____
Telephone # (mobile):_____ (work):_____ text okay: Y/N
Marital status: _____ Live with: _____Pets: _____
E-mail Address:_____ Email Reminders Preferred: Y/N
Text Reminders Preferred: Y/N

Occupation _____ Hrs. per week _____
Employer How long? _____
Work address _____

Health Insurance Information:

Health Insurance Co. Name & Address_____
Phone #: _____ Group#: _____
Policyholder's Name: _____ ID#_____
Patient's ID# (If different) _____

Emergency Contact Information:
Person to contact in an emergency _____
Relationship_____ Phone #_____
Address_____

Welcome! How did you hear about our clinic?

We request 24 hour notice for cancellation of appointments or a $25 fee will be charged. Thank you for your consideration.

I hereby give Dr. Kreger, permission to treat my condition as medically necessary. I authorize all Insurance payments to be made directly to Dr. Yvonne Justine Kreger. I consent for the release of all Information the Insurance company may request for filing the Insurance forms. I understand that I am responsible for any charges which are not fully covered by my Insurance.

Patient or Responsible Party Signature_____ Date_____

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I also understand that Dr. Kreger is not responsible if I take supplements or herbs that she does not recommend. I also understand that Dr. Kreger is not responsible if do not I comply with the treatment plan she provides. _____ (initial)

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

What are your most important health problems? List as many as you can in order of importance. Add more if you need to do so.

1)

2)

3)

4)

Allergies

Are you hypersensitive or allergic to...
Any drugs?
Any foods?
Any environmentals?

Current Medications

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Tobacco	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N	Sleeping pills	Y	N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) 4)
2) 5)
3) 6)

Typical Food Intake

Breakfast:
Lunch:
Dinner:
Snacks:
To drink:

GENERAL

Weight ___ lbs. Weight 1 year ago _____ ___ lbs.
Maximum Weight When
Height

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When during the day is your energy the best? worst?

REVIEW OF SYSTEMS

Y = a condition you have now **P** = a condition you have had before
N = never had
FOR THE FOLLOWING, PLEASE CIRCLE

MENTAL/EMOTIONAL

Mood Swings?	Y	N	P	Anxiety or nervousness?	Y	N	P
Poor concentration?	Y	N	P	Memory problems?	Y	N	P

ENDOCRINE

Hypothyroid?	Y	N	P	Heat or cold intolerance?	Y	N	P
Hypoglycemia?	Y	N	P	Diabetes?	Y	N	P
Fatigue?	Y	N	P	Seasonal depression?	Y	N	P

IMMUNE

Vaccinations?	Y	N	P	Reactions to vaccinations?	Y	N	P
Chronic Fatigue Syndrome?	Y	N	P	Chronic infections?	Y	N	P
Chronically swollen glands?	Y	N	P	Slow wound healing?	Y	N	P

SKIN

Rashes?	Y	N	P	Eczema, Hives?	Y	N	P
Acne, Boils?	Y	N	P	Itching?	Y	N	P

HEAD

Headaches?	Y	N	P	Migraines?	Y	N	P
Head injury?	Y	N	P				

EARS

Earaches?	Y	N	P	Impaired hearing?	Y	N	P
Dizziness?	Y	N	P	Ringing?	Y	N	P

NOSE AND SINUSES

Frequent colds?	Y	N	P	Nose Bleeds?	Y	N	P
Stuffiness?	Y	N	P	Hayfever?	Y	N	P
Sinus problems?	Y	N	P	Loss of smell?	Y	N	P

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	Sore tongue/lips?	Y	N	P

RESPIRATORY

Cough?	Y	N	P	Wheezing?	Y	N	P
Asthma?	Y	N	P	Bronchitis?	Y	N	P

CARDIOVASCULAR

Heart disease?	Y	N	P	High/Low Blood Pressure?	Y	N	P
Palpitations/Fluttering?	Y	N	P				

GASTROINTESTINAL

Heartburn?	Y	N	P	Belching or passing gas?	Y	N	P
Change in thirst?	Y	N	P	Change in appetite?	Y	N	P

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Bowel Movements — Constipation? Y N P
How often? _____ Diarrhea? Y N P
Is this a change? _____

URINARY

Increased frequency? Y N P — Frequency at night? Y N P
Frequent infections? Y N P

MUSCULOSKELETAL

Joint pain or stiffness? Y N P — Arthritis? Y N P
Muscle spasms or cramps? Y N P — Back pain? Y N P

HABITS

Do you exercise? Y N — Kind? _____ How often?

Average 6-8 hrs. sleep?	Y N	Enjoy your work?	Y N
Sleep well	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Any major traumas?	Y N	how many hours?	
Have a history of abuse?	Y N	Read?	Y N
Use recreational drugs?	Y N P	how many hours?	
Treated for drug dependence?	Y N	Add salt to food?	Y N
Do you eat 3 meals a day?	Y N	Use alcoholic beverages?	Y N P
Do you eat out often?	Y N	Treated for alcoholism?	Y N P
Do you go on diets often?	Y N	Do you use tobacco?	Y N P
Do you drink coffee?	Y N	Do you drink black tea?	Y N
Do you drink cola?	Y N	Do you eat refined sugar?	Y N

Family History (check those which apply)

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health (good or poor)	_____	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hayfever	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____

How much change are you willing to make for Improving your health!

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MINIMAL SOME COMPLETE

Welcome! I'm happy to help you! If you have any questions, just ask!

Yours in Health,
Dr. Yvonne