

# Nature's Way Medicine®

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Gender: M / F      Relationship Status: Married/Single/Other      Dominant Hand: L/R

Reason for Consultation: (*pain, ptsd, cancer, etc.*) \_\_\_\_\_

How did you hear about us? Doctor/Friend \_\_\_\_\_ Website \_\_\_\_\_

Google Search for " \_\_\_\_\_ " Other: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse / Significant Other: \_\_\_\_\_ Contact #: \_\_\_\_\_

List All Drug ALLERGIES (Including Latex): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current MEDICATIONS and Dosages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past SURGERIES with Approximate Dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**PAIN DESCRIPTION** (If any) Severity (1 – 10): \_\_\_\_\_ Describe Your Pain: \_\_\_\_\_

Location: \_\_\_\_\_

Duration: \_\_\_\_\_

Frequency: \_\_\_\_\_

Limits Activities / Responsibilities? Explain: \_\_\_\_\_

## MEDICAL HISTORY

Personal History of:	Yes	No	Explain
ALS			
Autism			
Cancer			
Crohn's Disease			
Depression/Anxiety			
Diabetes			
DVT/PE			
Glaucoma			
Heart Disease			
High Blood Pressure			
High Cholesterol			
HIV / AIDS			
Kidney Disease			
Liver Disease			
Multiple Sclerosis			
Muscle Spasms			
Parkinsons/Huntingtons			
PTSD			
Respiratory / COPD			
Seizures			
Sickle Cell Anemia			
Stroke			
Thyroid Disease			
Ulcerative Colitis			
Other:			



**FAMILY HISTORY** (Use *M – Mother*    *F – Father*    *S – Sibling*    *C – Child* )

Family History of:	Yes	Who	Explain
Adopted			
Abnormal Bleeding			
Abnormal Clotting			
Autoimmune Disorder			
Brain Tumor			
Breast Tumor			
Colon Cancer			
Diabetes			
Endocrine Disease			
Heart Disease			
High Blood Pressure			
Hemophilia			
Kidney Disease			
Liver Disease			
Lung Cancer			
Malignant Melanoma			
Ovarian Cancer			
Prostate Cancer			
Seizures			
Thyroid Disease			
Other Cancer			
Von Willebrand			
Other:			

**SOCIAL HISTORY**

**Tobacco:** Current / Prior / Never    Years \_\_\_\_\_    Daily Amount \_\_\_\_\_

**Alcohol:** None / Occasional / Daily    Frequency \_\_\_\_\_    Amount \_\_\_\_\_

**Marijuana :** Never / Current    Amount and types \_\_\_\_\_

**Other Drug Use:** Y / N    Details: \_\_\_\_\_



## Review of Systems

Please circle "Yes" or "No" as they relate to your health.

Constitutional:			Genitourinary:		
Unplanned Weightloss	Yes	No	Burning/Frequency	Yes	No
Fever	Yes	No	Blood in Urine	Yes	No
Chills	Yes	No	Hematology/Lymph:		
Eyes:			Easy Bruising	Yes	No
Glasses/Contacts	Yes	No	Enlarged Glands	Yes	No
Double Vision	Yes	No	Musculoskeletal:		
Cataracts	Yes	No	Joint Pain/Swelling	Yes	No
Ear, Nose, Throat:			Muscle Pain	Yes	No
Difficulty Hearing	Yes	No	Muscle Spasms	Yes	No
Sinus Trouble	Yes	No	Skin:		
Nasal Stuffiness	Yes	No	Rash/Sores/Itching	Yes	No
Cardiovascular:			Lesions	Yes	No
Chest Pain	Yes	No	Tears Easily	Yes	No
Murmur	Yes	No	Neurological:		
Fainting Spells	Yes	No	Numbness	Yes	No
Difficulty Lying Flat	Yes	No	Weakness	Yes	No
Palpitations/Heart Racing	Yes	No	Headaches	Yes	No
Respiratory:			Endocrine:		
Cough	Yes	No	Loss of Hair	Yes	No
Wheezing	Yes	No	Heat/Cold Intolerance	Yes	No
Shortness of Breath	Yes	No	Allergic/Immunologic:		
Gastrointestinal:			Hives/Eczema	Yes	No
Heartburn/Reflux	Yes	No	Psychiatric:		
Abdominal Pain	Yes	No	Anxiety/Depression	Yes	No
Constipation	Yes	No	Difficulty Sleeping	Yes	No
Nausea	Yes	No	Mood Swings	Yes	No

### CERTIFICATION AND CONSIGNMENT

I certify that **the above** information is correct and true to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes with regards to the above information.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



**FILL THIS OUT HOW YOU WOULD FEEL IF YOU DID NOT USE MARIJUANA**

**GAD-7**

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score \_\_\_\_\_ = Add Columns \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

(/File:GAD-7\_Pic.png)

**Scoring:** The total score for the 7 items can range from 0-21. Scores of 5, 10 & 15 are the cut-offs for mild, moderate and severe anxiety.

Goodman and Snyder suggest that during the subjective examination of a patient, one may want to ask specific questions regarding anxiety/depression.<sup>[5]</sup>

- Have you been under a lot of stress lately?
- Are you having some trouble coping with life in general and/or life's tensions?
- Do you feel exhausted or overwhelmed mentally or physically?
- Does your mind go blank or do you have trouble concentrating?
- Do you have trouble sleeping at night (difficulty getting to sleep, staying asleep, restless sleep, feel exhausted upon awakening)?
- Do you have trouble focusing during the day?
- Do you worry about finances, work, or life in general?
- Do you get any enjoyment in life?
- Do you feel keyed up or restless?
- Irritable and jumpy?
- On edge most of the time?
- Do you have a general sense of dread or unknown fears?
- Do you have any of these symptoms: a racing heart, dizziness, tingling and tingling, muscle or joint pains?

The authors also list questions specific to Asian patient/clients:<sup>[5]</sup>

- Do you feel you are having any imbalance of yin and yang?
- Is your chi (internal energy) low?
- Do you believe it is your destiny to have this condition or your destiny not to have this condition? (fatalism versus well-being approach to illness.)

## Associated Comorbidities

Comorbidities play an essential role in describing and understanding general anxiety disorders. The conditions of GAD may not be recognized as an emotional problem until the secondary disorder/ co-morbidity develops. Hoyer et al. state that epidemiological studies have found high rates of co-morbidity in GAD.<sup>[15]</sup>

Generalized anxiety disorder is most often associated with other disorders that can include other anxiety disorders, depression, and substance abuse. GAD can also lead to or worsen pre-existing conditions such as insomnia, digestive or bowel problems, headaches, and bruxism (teeth grinding).<sup>[2][9]</sup>

Other associated anxiety disorders can include panic disorder, phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), or adjustment disorder with anxious mood (those with an organic illness).<sup>[1][5]</sup>

## Consent Form

By signing below, I understand that using marijuana may cause short term side effects like elevated mood, increased appetite, red eyes, dry mouth, and paranoia. More serious problems like pneumothorax are rare but have been documented. There may be a decreased ability to operate machinery and drive a vehicle. For this reason, it is advised not to drive or use heavy machinery while under the influence of marijuana. These short-term side-effects decrease with use and familiarity to its effects.

I have discussed the risks and benefits and appropriate forms and methods of use of marijuana with my physician during my appointment at Nature's Way Medicine.

Name: \_\_\_\_\_ Date: \_\_\_\_\_