Carol Bobovski, N.D.
15613 Bel-Red Road, STE B.
Bellevue, WA. 98008
P: 425-947-1970 / F: 425-947-1971

Office Visit Date: _____

Name: _____ **Age:** _____ **Date of Birth:** _____
Nickname/preferred name: _____ Gender: M F ____

List Current Health Concerns

1. _____ 2._____
3. _____ 4. _____

Goals/Expectations:

_____
_____
_____

What are the most significant measures you have taken to improve your health?

_____
_____
_____

Have you seen a naturopath before? No Yes
Are you currently seeing one? No Yes, Doctor's name: _____
Do you have a medical doctor? No Yes, Doctor's name: _____
Are you currently seeing a chiropractor, acupuncturist, counselor, or any other health care professional? Please list: _____

_____

List the prescribed medications, non-prescription medications, herbals, vitamins and minerals you are currently taking:

_____
_____
_____

Please list any medications you have been prescribed **but are not taking**: _____
Do you have a history of allergies/ reactions: **No** **Yes** (please list include your reaction):
Medications: _____
Environmental: _____
Foods: _____
Other: _____

Please list any major illnesses, hospitalizations, surgeries (date and brief description):

_____
_____
_____

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Name _____

Height: _____
Weight: _____ Weight 1 year ago: _____ Max. weight: _____

Personal and Family History:

(Please indicate if **you or a family member** has experienced the following health complaints)

Unknown / Adopted:

AIDS/HIV_____	Heart Disease_____	
Alcoholism_____	High Blood Pressure _____	
Allergies _____	Hypoglycemia _____	Stroke _____
Anemia_____	Kidney Disorder _____	Suicide_____
Arthritis _____	Mental Illness _____	TB _____
Asthma _____	Migraines _____	Thyroid disorder__
Cancer _____		Ulcer _____
Depression _____	Obesity _____	High Cholesterol_
Diabetes _____	Psoriasis _____	_____
Drug Problems _____	Senility _____	_____
Eczema _____	Sexual abuse _____	_____
Gout _____	Seizures _____	_____

Review of Symptoms:

(Circle Yes, if experienced with in the last 1 month):

Constitutional _____			**Endocrine** _____		
Good Recent Health	Yes	No	Excessive thirst/urination	Yes	No
Recent Weight Change	Yes	No	Hair loss or unusual growth	Yes	No
Night sweats, Fever	Yes	No	Cold hands/feet	Yes	No
Fatigue	Yes	No	Hormone Problems	Yes	No
Cardiovascular _____			**Urinary**_____		
Chest pain	Yes	No	Blood in urine	Yes	No
Palpitations	Yes	No	Pain/Burning w/ urination	Yes	No
Heart Trouble	Yes	No	Kidney Stones	Yes	No
Swelling hands/feet	Yes	No	Recurrent Bladder Infections	Yes	No
Lightheaded/dizziness	Yes	No	Difficulty with voiding	Yes	No

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Musculoskeletal			**Ears/Nose/Throat/Mouth**		
Muscle pain/cramps	Yes	No	Hearing loss or ringing	Yes	No
Stiffness/Swelling Joints	Yes	No	Sinus Problems	Yes	No
Trouble Walking	Yes	No	Sore Throat/Voice Change	Yes	No
Respiratory			**Neurological**		
Shortness of Breath	Yes	No	Frequent Headaches	Yes	No
Cough	Yes	No	Paralysis or Tremors	Yes	No
Wheezing/Asthma	Yes	No	Seizures	Yes	No
Difficulty Breathing	Yes	No	Numbness or Tingling	Yes	No
Sleep Apnea	Yes	No			
Skin			**Male/Female**		
Rashes or itching	Yes	No	Menstrual Problems	Yes	No
Abnormal Nails	Yes	No	Sexual Problems	Yes	No
Dry Skin	Yes	No	Testicle/Ovary Pain	Yes	No
Discolored Skin	Yes	No	Infertility	Yes	No
Body Odor/Excessive Sweat	Yes	No	Breast concerns (lumps, discharge/pain)	Yes	No
Eyes			**Hemotologic/Lymphatic**		
Wear glasses/contacts	Yes	No	Anemia	Yes	No
Blurred/double vision	Yes	No	Bruise Easily	Yes	No
Eye Disease/Injury	Yes	No	Slow to Heal	Yes	No
Eye Pain	Yes	No	Enlarged glands	Yes	No
Allergies			**Psychiatric**		
Food Allergies	Yes	No	Depression	Yes	No
Hay Fever	Yes	No	Anxiety/Panic Attacks	Yes	No
Chemical Sensitivity	Yes	No	Confusion/Memory Loss	Yes	No
			Insomnia	Yes	No
			Suicidal Ideation	Yes	No
Digestion					
Indigestion/ Belching/Reflux	Yes	No	Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No	Hemorrhoids	Yes	No
Early Fullness	Yes	No	Rectal Bleeding	Yes	No
Gas/Bloat	Yes	No	Mucous in Stool	Yes	No
Diarrhea	Yes	No	Abnormal Stool Color	Yes	No
Constipation	Yes	No			

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Name: _____

Women:
Last menses start date: _____ Regular cycle Irregular cycle
Painful menses? Yes No
Premenstrual Complaints? Yes No If yes, list: _____
Are you planning to conceive now or in the near future? Yes No
If sexually active, what form of birth control do you use? _____

Lifestyle

Stressors: Rate level of Stress, (10 = high stress, 1 = low stress) _____
Top stressor currently or in recent past, if any: _____

Exercise:
Do you exercise regularly: Yes No
Regimen: _____
Frequency/Duration:_____
How long have you been on this program: _____

Diet:
Do you eat breakfast? Yes No Time: _____
Describe typical meal: _____
Do you eat lunch? Yes No Time: _____
Describe typical meal: _____
Do you eat dinner? Yes No Time: _____
Describe typical meal: _____
Do you snack? Typical snacks:_____
What are your food cravings, or attractions: _____
Coffee: _____cups/d Caffeinated Tea: _____cups/d Chocolate: _____/d
Water Intake: _____glasses/d
Are there any foods that disagree with you/or that you avoid (meats, etc): _____
_____

Habits:
Do you smoke or chew (tobacco)? Yes No _____packs/day or amount/day
Do you drink alcoholic beverages? Yes No _____drink per: day week month
Other: _____
Sleep: Rate the quality of sleep (10 is good, 1 is poor): _____
Anything else you want the doctor to know: _____

☐ Reviewed with patient: _____

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Contact Information:
First Name: _____ M.I. _____ Last Name:_____
Date of Birth: _____ Gender: M / F **S**ocial **S**ecurity #: _____
Other names nicknames records may be kept under: _____
Spouse/Partners Name: _____
Address: _____ Phone Number:_____
_____ Cell Number: _____
(zip code)_____ Work Number: _____
E-mail: _____
Mailing Address if different from above: _____
(Your address, phone number, and e-mail will be used only for patient care, billing, insurance, and referral related reasons.)

Can I leave messages on your: (please circle) **e-mail cell # home # work#**
Can Docere Natural Health text you regarding upcoming office visits **YES NO**
Mother's full name (if patient is a minor): _____
Father's full name (" "): _____

Insurance Information:
Name of insured: _____ Relationship to patient:_____
Insurance Carrier: _____ Plan name: _____
Policy # _____
Group # _____
Address: _____
Phone # _____
N.D. benefits verified: Yes No

Emergency Contact Information:
Name: _____Relationship to you: _____ Number:_____

Referral Information: if appropriate:
Physicians Name (Primary Care Provider, etc): _____
Clinic Name/Location: _____
Clinic Phone Number: _____

How did you hear about the clinic: _____

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Docere (Do·se·re): [Latin] To Teach. Original word for Doctor.

Dr. Carol Bobovski is a licensed naturopathic physician practicing in Bellevue, Washington. She earned her Doctorate degree at Bastyr University in Kenmore. After graduation, Dr. Bobovski continued her education through an advanced two year residency and additional gynecological training. She has been in practice for 15 years.

Dr. Bobovski is dedicated to the art and science of natural healing, and blends cutting edge research with age-old wisdom. She embodies the concept of Docere, or doctor as teacher, the belief of educating, empowering, and guiding men, women and children in the journey to reclaim their health and optimal vitality. Her goal is to restore a healthy foundation by addressing and treating the underlying cause(s) of one's health complaints, in addition to alleviating the symptoms. She addresses the whole person (physically, mentally, emotionally and spiritually), and provides the best in diet/nutritional therapy, botanical medicine, homeopathy, metabolic detoxification, lifestyle counseling and hormone balancing.

Dr. Bobovski recognizes the uniqueness in each and every patient. She strives to provide a comprehensive treatment plan that addresses each individual's specific health recovery needs and goals. At Docere Natural Health each patient will receive compassionate care, quality naturopathic medicine and the opportunity to become educated in the process of health and wellness recovery. We look forward to meeting you.

Please complete the enclosed paperwork and bring to your visit. You may also fax the forms to Dr. Bobovski at 425-947-1971 or email to staff@docerenaturalhealth.org . If you have health insurance, please bring your insurance card and identity card with you to your visit. Thank you very much.