Welcome to Wellness!

I'm here to offer the best of integrative health care for everyone in your family.

Dr. Ries is currently practicing at 2456 NW Northrup St, Suite 1A, within the Marshall St. Professional Building. Clinic entrance is on the Northrup St. side of the building. There is dedicated parking in two lots adjacent to the clinic, as well as abundant street parking. Please arrive a few minutes early to allow for patient check in prior to your first appointment.

24-hours notice is required f you need to reschedule or cancel an appointment. *Late cancellation or missed appointments incur a $50.00 fee*. You can cancel or reschedule your appointment via the patient portal, by emailing me at doctor.darcy@gmail.com, or by leaving a message at (503) 277-3113.

I look forward to helping you on your journey to wellness!

In health,
Dr. Darcy A. Ries

Here's a checklist to help get you ready for your first visit.

- New patient paperwork filled out to the best of your ability.
- Bring all the supplements/medications you are currently taking.
- If you have *recent* labwork or imaging results you feel are relevant, please bring these to your appointment.
- If you are scheduled for a physical medicine appointment, please wear pants (no skirts) to your visits.
- Avoid wearing heavy perfumes.
- The first visit will last approx. 75-90 min.

Adult Intake Form

Name: ____ Date: ___________________________
Address: ____ City: ____________________________
State: ________ Zip: _____________ Telephone (Home): ______________________
(work/cell): _______________________ Email: ____________________________________
Age: _____ Date of Birth: ______________ Gender identity: ______________________
____ Married ___Separated ___ Divorced ___Widowed ___ Single ____ Partnership
Who do you live with: __________________________ Number of children: __________
Occupation: ____________________________________ Hours per week: ______________
Employer: ______________________________________
How did you hear about this clinic/Dr. Ries: ____
___Website ___Google search ___Yelp ___Insurance ___Other
Google keywords: ____
If from a friend or another provider, whom should we thank: ________________________
Emergency contact: _____________________________ Relationship: ______________________
Phone number: __________________________________

Health History Questionnaire

What are your most important health problems? List in order of importance.
1.) ____
2.) ____
3.) ____
4.) ____
5.) ____

Family History

Do you have any family history of the following? (Please indicate family member and age)

Cancer:	Kidney Disease:	Asthma:
Tuberculosis:	Diabetes:	Epilepsy:
Stroke:	Hay Fever:	Heart Disease:
Arthritis:	Anemia:	Hives:
High blood pressure:	Anxiety:	Glaucoma:
Thyroid disorders:	Depression:	Alcoholism:
Other:	Other mental illness:	

Hospitalizations/ Surgery/ Accidents (event and year)

1.) ____
2.) ____
3.) ____
4.) ____
5.) ____

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List any broken bones and dislocations: ______________________________

Were you ever knocked unconscious? Y N Have you ever had a lapse of memory? Y N

Patient Evaluation Questionnaire:

1. Please rate on a scale how serious you are about getting well. (circle answer)
   Not Serious 0 1 2 3 4 5 6 7 8 9 10 Very Serious
2. Are you willing to follow a treatment program designed to help you return to health by treating the cause? Yes No
3. Are you willing to take nutritional and/or homeopathic supplements?Yes No
4. Are you willing to make dietary changes? Yes No
5. Are you willing to start a moderate exercise program? Yes No
6. Have you ever been treated by a Chiropractor or Naturopath? Yes No
   a. If yes, how were your results? ______________________________
      ____
7. Please rate your stress:
   No Stress 0 1 2 3 4 5 6 7 8 9 10 Total Stress
8. Are any doctors or other practitioners currently treating you? Yes No
   a. If yes, please list: ______________________________
9. How does your condition affect you? ______________________________

Toxic Profession, Past or Present

(Artist, graphic designer, dental assistant, gas station worker, painter, industry, cleaners etc.) Please indicate age and number of years worked

Age: ____________________ Age: ____________________
Age: ____________________ Age: ____________________

Major Psychological Trauma

Age: ____________________ Age: ____________________
Age: ____________________ Age: ____________________

Serious Disease or Infections
(Pneumonia, mono, TB, cancer, heart attack, stroke, hepatitis, etc.)

Age: ____________________ Age: ____________________
Age: ____________________ Age: ____________________

Long periods on prescriptions or street drugs

Age: ______________________________
Age: ______________________________

Long visits or lived in a foreign country (India, Mexico, Africa, etc.)

Age: ______________________________
Age: ______________________________
Treated for parasites or infections? Yes No

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Allergies

Are you hypersensitive or allergic to any drugs? ________________________________
____

Food allergies or sensitivities: ____
____

Environmental allergies: ____

Current medications

Please circle any medications you *currently* take:
Thyroid medication   Birth control pills   Antacids   Sleeping pills   Antibiotics
Laxatives   Cortisone   Tranquilizers   Pain relievers   Appetite suppressants

Please list specific prescription or over the counter medications, vitamins or other supplements you are *currently* taking. *Please include dosages.*

____
____
____
____
____

Lifestyle & habits

Main interests and hobbies: ____

Do you exercise? Yes No If yes, what kind? _____________________________________
If yes, how often? ____
Do you average 7-8 hours of sleep? Yes No   Do you awake rested? Yes No
What time of day is you energy best? _________________ Worst? _____________________
Do you have a supportive relationship? Yes No
History of abuse? Yes No Past   Use recreational drugs? Yes No Past
Alcohol: _____ drinks per day / week   Caffeine intake: _________________________
Do you eat 3 meals per day? Yes No   Do you eat out often? Yes No
Do you enjoy your work? Yes No   Take vacations? Yes No
Spend time outside? Yes No   Watch television? Yes No
Do you smoke? Yes No Past How much per day? _____ How many years? _____
Do you have a religious or spiritual practice? Yes No If yes, what? _______________
How many hours per week? _______________________

Review of systems

Y = condition you have **N**= Never had **P**= Condition in past **V**= Vaccinated

Have you had, or do you have any of the following conditions?

Appendicitis	Y N P	Chicken Pox	Y N P V
Polio	Y N P V	Alcoholism	Y N P
Whooping cough	Y N P V	Epilepsy	Y N P
Anemia	Y N P	HIV	Y N P
Measles	Y N P V	Multiple Sclerosis	Y N P
Mumps	Y N P V		

General

Chills	Y N P	Loss of sleep	Y N P
Convulsions	Y N P	Loss of weight	Y N P
Fainting	Y N P	Neuralgia	Y N P
Fatigue	Y N P	Sweats	Y N P
Fever	Y N P		

Mental/Emotional

Treated for emotional problems	Y N P	Depression	Y N P
Mood Swings	Y N P	Anxiety/ nervousness	Y N P
Considered Suicide	Y N P	Tension	Y N P
Poor concentration	Y N P	Memory problems	Y N P

Endocrine

Hypothyroid	Y N P	Diabetes	Y N P
Hypoglycemia	Y N P	Excessive hunger	Y N P
Excessive thirst	Y N P	Seasonal depression	Y N P
Fatigue	Y N P	Night Sweats	Y N P
Heat/cold intolerance	Y N P		

Immune

Chronic fatigue	Y N P	Vaccine reactions	Y N P
Chronic swollen glands	Y N P	Chronic infections	Y N P
Slow healing	Y N P		

Neurologic

Symptom		Symptom	
Seizures	Y N P	Numbness/tingling	Y N P
Muscle weakness	Y N P	Easily stressed	Y N P
Loss of memory	Y N P	Loss of balance	Y N P
Vertigo/dizziness	Y N P	Fainting	Y N P
Paralysis	Y N P		

Skin

Symptom		Symptom	
Rashes	Y N P	Lumps	Y N P
Eczema/hives	Y N P	Itching	Y N P
Acne/boils	Y N P	Hair loss	Y N P
Color change	Y N P	Bruises easily	Y N P

Head, Eyes, Ears, Nose, Throat

Symptom		Symptom	
Headaches	Y N P	Frequent colds	Y N P
Migraines	Y N P	Stuffy nose	Y N P
Head injury	Y N P	Runny nose	Y N P
Jaw/TMJ problems	Y N P	Sinus problems	Y N P
Spots in eyes	Y N P	Nose bleeds	Y N P
Impaired vision	Y N P	Hay fever	Y N P
Blurriness	Y N P	Loss of smell	Y N P
Color blindness	Y N P	Sore throat	Y N P
Double vision	Y N P	Teeth grinding	Y N P
Cataracts	Y N P	Gum problems	Y N P
Glasses or contacts	Y N P	Dental cavities	Y N P
Eye pain/strain	Y N P	Sores on tongue	Y N P
Tearing/dryness	Y N P	Sores on lips	Y N P
Glaucoma	Y N P	Hoarseness	Y N P
Impaired hearing	Y N P	Difficulty swallowing	Y N P
Earaches	Y N P	Goiter	Y N P
Ringing	Y N P	Swollen glands	Y N P
Dizziness	Y N P		

Respiratory

Symptom		Symptom	
Cough	Y N P	Shortness of breath	Y N P
Spitting up blood	Y N P	Tuberculosis	Y N P
Asthma	Y N P	Spitting up phlegm	Y N P
Pneumonia	Y N P	Wheezing	Y N P
Emphysema	Y N P	Bronchitis	Y N P
Pain on breathing	Y N P		

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Cardiovascular

Heart disease	Y N P	Varicose veins	Y N P
High blood pressure	Y N P	Murmurs	Y N P
Low blood pressure	Y N P	Blood clots	Y N P
Pain over heart	Y N P	Phlebitis	Y N P
Poor circulation	Y N P	Rheumatic fever	Y N P
Rapid heart	Y N P	Swelling in ankles	Y N P
Slow heart	Y N P	Palpitation/fluttering	Y N P
Stroke	Y N P		

Gastrointestinal

difficulty-swallowing	Y N P	Heartburn	Y N P
Change in thirst	Y N P	Change in appetite	Y N P
Nausea	Y N P	Constipation	Y N P
Vomiting blood	Y N P	Diarrhea	Y N P
Blood in stool	Y N P	Gallbladder trouble	Y N P
Abdominal pain	Y N P	Ulcer	Y N P
Belching	Y N P	Hemorrhoids	Y N P
Passing gas	Y N P	Poor appetite	Y N P
Black stools	Y N P	Poor digestion	Y N P
Liver trouble	Y N P		

Bowel movements: How often? ____________________ Is this a change? _____________
Are you bowel movements well formed? Y N Color ____________________________

Urinary

Pain on urination	Y N P	Kidney stones	Y N P
Frequency at night	Y N P	Blood in urine	Y N P
Frequent infections	Y N P	Kidney infection	Y N P
Increased frequency	Y N P	Prostate trouble	Y N P
Incontinence	Y N P		

Male reproductive

Hernia	Y N P	Premature ejaculation	Y N P
Testicle pain	Y N P	Testicular mass	Y N P
Venereal disease	Y N P	Prostate disease	Y N P
Impotence	Y N P	Discharge or sores	Y N P

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Female Reproductive

Age of first Menses	______ yrs old	Discharge	Y N P
Age of last menses	______ yrs old	Herpes	Y N P
Length of cycle	______ days	Venereal disease	Y N P
Duration of menses	______ days	IUD	Y N P
Painful menses	Y N P	Birth control	Y N P
Heavy/excessive flow	Y N P	What type?	____________
PMS	Y N P	# of pregnancies?	____________
Endometriosis	Y N P	# of live births?	____________
Ovarian cysts	Y N P	Miscarriages?	____________
Difficulty conceiving	Y N P	Abortions?	____________
Are cycles regular	Y N P	Hot flashes	Y N P
Bleeding between cycles	Y N P	Lump in breast	Y N P
Pain during intercourse	Y N P	Clotting	Y N P

Have you had a mammogram? Y N If yes, was it normal?
Last pap smear date? __________________ Was it normal? Yes No

Musculoskeletal

Backache	Y N P	Stiff neck	Y N P
Foot trouble	Y N P	Swollen joints	Y N P
Pain between shoulders	Y N P	Tremors/twitching	Y N P
Painful tail bone	Y N P	Arm trouble	Y N P
Muscle weakness	Y N P	Numbness/tingling	Y N P

If you have current musculoskeletal pain, please complete the following:

Locations: ____
How long have you had this condition? ______________________________
Is this condition Getting worse The same Improving
Was this caused by an injury or accident? Y N
If no, When did you first notice it? _________________________________
The pain is: occasional frequent constant
Does pain affect your sleep? Y N P
Does pain affect your work? Y N P
Have you seen other doctors for this condition? Y N
If yes, doctor's name: ____

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