

NEW PATIENT INFORMATION

Please print

Full Name _____ Date of Birth _____ Gender _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone () _____ 2nd Phone () _____

Email _____ Marital Status _____ Referred by _____

Occupation _____ Employer _____

Person to contact in case of emergency _____

If under 18 years old, name of parent or guardian _____

Other health professionals you are seeing at this time and for what reason _____

What are your primary health concerns?

1. _____
2. _____
3. _____

Please list all current prescription medications

Name	Why you take it
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Herbs, Supplements, Vitamins you currently take

Name	Why you take it
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past long-term medications? _____

Please list all known **allergies** including specific reactions to medications _____

Do you use? ___ Alcohol Type and frequency _____
 ___ Tobacco # of years _____ packs per day _____
 ___ Coffee # of cups per day _____

Childhood illnesses? _____

Previous hospitalizations? _____

Previous surgeries, including any problems from anesthesia? _____

Major injuries or scars? _____

Psychiatric illnesses and admissions? _____

Estimated current body weight _____ **Highest and lowest weight in last 2 years** _____

Family Medical History (circle conditions)

Diabetes Cancer Heart Disease Asthma Epilepsy Mental Disorders

Check all of the boxes below that are now or have been a part of *your* personal health history

	Current	Past		Current	Past		Current	Past
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Gall Stones	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	HIV +	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>

Circle the 3 foods you eat most.

Place a ~~line through~~ the 3 foods you eat least.

Dairy
Eggs
Fish
Fruits
Grains and breads
Legumes (beans, lentils, sprouts)
Meat or poultry
Nuts and Seeds
Sweets or desserts
Vegetables and salads

Circle the 3 beverages you drink most.

Place a ~~line through~~ the 3 beverages you drink least.

Black or Green tea
Herbal tea
Fruit Juice
Vegetable juice
Milk
Soda/non-juice sweet drinks
Soy/Rice/Almond milk
Coffee
Water
Wine/Beer/Cocktails

Woman Only

Age of first period _____ Average days in your cycle _____ Average days of flow _____

Do you currently experience: _____ cramps _____ PMS _____ itching
_____ vaginal discharge _____ Clots _____ Spotting

Birth control history (methods and years used): _____

Obstetric history (number of pregnancies, births, abortions, miscarriages) _____

Gynecological history (Fibroids, PID, Endometriosis, etc.) _____

History of STI's (Sexually Transmitted Infections) such as herpes, chlamydia, warts, etc.) _____

Last PAP? _____ Results of PAP? _____

Are you or might you be pregnant? _____

If menopausal, age of onset of menopause _____ Menopausal difficulties _____

Other gynecological problems? _____

Men Only

Genital or scrotal pain? _____ Discharge from penis? _____ Fertility difficulties? _____

Reduced libido? _____ Impotence or premature ejaculation? _____

Vasectomy? _____ Prostate problems? _____

History of STI's (Sexually Transmitted Infections) such as herpes, chlamydia, warts, etc.) _____

Other problems or issues? _____

Office policies:

Payment for office visits and herb/supplements are due at the time of service unless otherwise pre-arranged. I accept cash and checks. It is my policy that I do not offer third-party billing. If you have insurance coverage, it is your responsibility to submit all claims for reimbursement of any treatments. I am happy to provide any assistance you may need in gathering information for your claim. Please note that most insurance carriers do not reimburse for any herbal or nutritional supplements.

If you need to cancel or reschedule your appointment, please give 24 hours notice so that I may utilize the time for someone else. If you are unable to do so, a late cancellation fee of an office visit will be imposed.

I have read the above statement and understand that I am financially responsible for all treatments and herb/supplements received.

Signature _____ Date _____

