New Patient Information

Thank you for carefully filling out our New Patient Information. This comprehensive questionnaire will help us to better serve you by providing a wholistic perspective on your condition. Please feel free to write in added detail on any issue or concern.

Today's Date: _____

Patient Name: _____Age: _____ DOB: _____

Address: _____

Email: _____

Phone: (h) _____ (c) _____

Which is the best phone # for appointment reminders or messages? _____

Marital status: S / M / D / W Name of spouse or significant other: _____

In case of Emergency: _____ Phone: _____

children _____ names: _____

Occupation: _____ Employer: _____

Employer complete address: _____

Insurance name: _____Group # _____

Primary Cardholder: _____Relationship _____Phone_____

Your health care team:

Primary Care Physician: _____ City: _____

Other specialist and therapists (including MD, DC, Physical Therapist, Acupuncturist, ND, etc):_____

_____

Who referred you to us? _____ Phone_____

How else did you hear about us?: _____

Naturopathic Physicians Group

Your Health Concerns

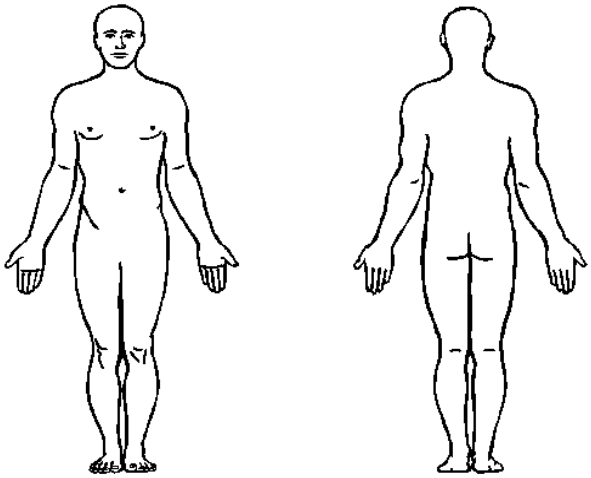
Please prioritize your reason for this office consult. List your current health concerns and problems in order of importance:

1) _____
2) _____
3) _____
4) _____

Please Prioritize your Pain or Physical concerns

1) _____
2) _____
3) _____
4) _____

Circle Pain Location below:



Do you have any of the following Symptoms:

Weakness: Y N

Numbness: Y N

Tingling: Y N

Stiffness: Y N

Muscles Spasms: Y N

Tremors: Y N

Nighttime Pain Y N

Lifestyle

Good Energy scale (1-10=great): _____ When Fatigued (bad=1-10) _____ Your Best time of day _____

Circle if Yes:

3 Meals per day Sugary Snacks Chocolate Ice Cream

Smoke/Tobacco use Alcohol use Caffeine use Recreational drug use

Any alcohol or drug addiction or treatment

SLEEP PATTERNS

Bedtime_____ Wake up Time_____Do you Wake refreshed? Y N Do you wake up during the night? Y N

How many hours of sleep per night on average? _____

Circle if Yes: Nighttime Urination Nap during the day Grind teeth: Snore: Insomnia: Nightmares:

EXERCISE

Present Weight:_____ Is weight a current concern: Y N Desired Weight: _____

What types of exercise? 1. _____ 2._____ 3._____

Duration of exercise? 1. _____ 2._____ 3._____

How often? 1. _____ 2._____ 3._____

Medical History, Medications and Supplements

Any Known Drug Allergies_____
Any Known Food Allergies_____

List all Prescription Medicines

Drug	*Dosage*	*How long?*	*Reason*	*Any side effects?*

List all Nutrients, Supplements and OTC's: use back of page if more space needed

OTCD/Nutrients/Supplements	*Dosage*	*How long?*	*Reason*	*Any side effects?*

How long ago was most recent lab testing? _____

Please list your recent imaging related to your current health issues the area imaged, Example: Rt shoulder MRI 2015

X-Ray: _____
MRI or CT Scans: _____
Ultrasounds: _____
Bone density/Mammogram: _____

List recent surgeries:

1) _____ 2)_____
2) _____ 4)_____
3) _____ 6)_____

Infectious Disease Please CIRCLE if you have had the following infections:

Hepatitis HIV/AIDs Tuberculosis Valley Fever
Ebstein Barr Virus Lyme disease Candida Mycobacteria Pneumonia UTI Sinus
Have you had any other chronic Infections? _____

Toxin Exposure Circle if any suspicious exposure to:

Mold Farm or Yard Chemicals Pest services Gasoline Paints
Metals: Lead / mercury / arsenic Fumes Perfumes Dry Cleaning Other_____
Describe your exposure:_____

OVERVIEW OF BODY SYSTEMS Please circle any conditions you have:

SKIN

Skin Cancer Rash Acne Hives Itchy Eczema Psoriasis Skin Color Change

HEAD/Neck/Sinus

Headaches Headache Intensity (1=10): _____ H/A frequency:_____
Neck Pain Head Injury Hair loss Swollen glands Enlarged Thyroid

Brain/Nerves

Depression Anxiety Memory concerns Cognitive concerns
Head Injury Seizures Fainting Tremor

NOSE

Frequent colds Post nasal drip Nasal Congestion Seasonal allergies Sinusitis Nosebleeds

EYES

Dry eyes Blurry/double vision Glaucoma Itchy Eyes Cataracts

MOUTH/THROAT

Low Thyroid Hashimoto's Hyperthyroid Nodules or Swellings in neck or Thyroid Sore throats
Dental issues_____ Mercury fillings Bad Breath Gum disease Canker/Cold sore Loss of taste

RESPIRATORY

Allergies Cough Short of breath COPD Asthma Wheezing Recurrent Lung Infections

HEART/CIRCULATION/CARDIOVASCULAR

High blood pressure Low Blood Pressure Chest pain/angina Heart attack/MI Arrhythmia Heart Murmur
Poor Circulation to legs Leg Swelling/Edema Varicose Veins History of Rheumatic fever

URINARY TRACT

Reoccurring Bladder infections Urgent need urinate Pain w/urination Incontinence
Kidney stones History of Kidney Disease Discharge/blood

GASTROINTESTINAL

Heartburn/GERD Bloating: Indigestion Gas Vomiting: Nausea:
Hemorrhoids Diarrhea/loose BM: Constipation Change in appetite:
Gall Bladder disease: Liver disease Colon Cancer

MENTAL/EMOTIONAL

Depression Anxiety Anger Mood Changes/irritability
High-strung/tense Fear/Panic: Psychiatric hospitalization Suicidal

You & Your Family Disease History

Do you have or had the following Disease?	YOU/Self	Father or Mother	Grandparents	Any other details?
Diabetes	Y N	Y N	Y N	_____
High Blood Pressure:	Y N	Y N	Y N	_____
Stroke	Y N	Y N	Y N	_____
Asthma	Y N	Y N	Y N	_____
Cancer	Y N	Y N	Y N	_____
Autoimmune Disease	Y N	Y N	Y N	_____
Thyroid Disease	Y N	Y N	Y N	_____
Mental Health: Depression/Anxiety	Y N	Y N	Y N	_____

MEN ONLY

Fatigue Sexual function concerns Exercise Program Testosterone testing
Prostate concern Urination >2xNight Testicular Concern Erectile Dysfunction
Low Back Pain Knee Pain Shoulder Pain

USE OF HORMONE REPLACMENT THERAPY

Currently using HRT_____ Dosage_____ Frequency_____ Have you used HRT in the past? Yes NO
If yes. please mark which: Oral_____ Creams___ Lozenge___ Patch___ Pellets___ Shots___

WOMAN ONLY HEALTH HISTORY

USE OF HORMONE REPLACMENT THERAPY

Currently using HRT: Y N P Have you used HRT in the past: Y N P
If yes. please mark which: Creams___ Lozenge___ Patch___ Pellets___ Pills___ Shots___ Other___
Please list ingredients and dosage of current HRT_____

Your Menstrual Cycle, Menopause or Hormone concerns:
_____
_____
_____

GYN MEDICAL HISTORY

Cancer: Y P N If yes or past please describe:_____
STD Concerns : Y P N :_____
Prone to:
Breast cysts: Y P N UTI: Y P N Endometriosis: Y P N
Ovarian cysts: Y P P Fibroids: Y P N Stomach pain: Y P N

MENSTRUAL CYCLES

Age period first started:_____ Current period: Regular___ Irregular___ Menopause___
PMS symptoms if any:
_____
How long is each period_____ How often is period_____

BIRTH CONTROL

Birth control pill: Y P N How long:_____ Depo shot: Y P N How long:_____
Any symptoms: yes,xplain:_____
Cervical cap: Y P N Diaphragm: Y P N IUD: Y P N
Hysterectomy: Y N Tubal ligation: Y N

PREGNANCY

Infertility: Y P N Miscarriage/Abortions: Y N Live birth: Y N
Number of pregnancies:_____ Number deliveries:_____ Did you breastfeed? _____
Names and Ages of children now: _____