

New Patient Information

Name _____ Date _____
 Address _____
 City _____ State _____ Zip _____
 Home # _____ Cell# _____ Work# _____
 E-Mail _____ Occupation _____
 Referred By _____ B-Day _____

| | | | |
|------|-----|-----|-----|
| Age: | Wt: | Ht: | BP: |
|------|-----|-----|-----|

What is your main complaint or area of interest? _____

Family History (check all that apply):

| | |
|----------------------------|------------------------------|
| Stroke _____ | Diabetes _____ |
| High BP _____ | Weight Problems _____ |
| Depression _____ | Ulcer _____ |
| Heart Disease _____ | Psoriasis _____ |
| Arthritis (RA or OA) _____ | Glaucoma _____ |
| Cancer ___ Type? _____ | Family Side: ♀ _____ ♂ _____ |

Personal History (check all that apply):

| | |
|--|---|
| <input type="checkbox"/> Arthritis <input type="checkbox"/> RA <input type="checkbox"/> OA <input type="checkbox"/> Stroke <input type="checkbox"/> High Cholesterol How High? _____ <input type="checkbox"/> High Blood Pressure How High? _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Metabolic Syndrome <input type="checkbox"/> Insulin Resistance <input type="checkbox"/> Low Blood Sugar <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Multiple Chemical Sensitivities <input type="checkbox"/> Infectious Mononucleosis <input type="checkbox"/> Frequent Colds/Flu <input type="checkbox"/> Herpes/ HPV <input type="checkbox"/> Cold Sores <input type="checkbox"/> Cancer What type? _____ Chemo? _____ Rads? _____ Steroids? _____ <input type="checkbox"/> Surgeries What type? _____ | <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Headaches <input type="checkbox"/> Chronic Tension <input type="checkbox"/> Migraines <input type="checkbox"/> Cluster <input type="checkbox"/> Hormonal <input type="checkbox"/> Food Allergies To What? _____ <input type="checkbox"/> Seasonal Allergies To What? _____ <input type="checkbox"/> Medication Allergies To What? _____ <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Hot Flashes <input type="checkbox"/> PMS <input type="checkbox"/> Birth Control Pills/ Hormones <input type="checkbox"/> Weight Problems <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal Cramping/ Bloating <input type="checkbox"/> Yeast Infections <input type="checkbox"/> Low Libido <input type="checkbox"/> Ulcers |
|--|---|

What Medications and Dosages are you taking? List all please:

What Vitamins and herbal supplements are you taking? List all please:

Do you eat, drink, or use (circle all that apply):

- | | | |
|--|----------------|-----------------------|
| Antacids | Protein Drinks | Appetite Suppressants |
| Aspirin | Alcohol | Coffee |
| Tylenol | Tap Water | Decaf Coffee |
| Ibuprofen | Bottled Water | Diet Soda |
| Laxatives | Tea | Soda |
| Refined Sugars | Candy | White Bread |
| Margarine | Butter | Fast Foods |
| Chewing Gum | Fried Foods | Chips |
| Salt (w/out tasting) | Tobacco | Cigarettes |
| Artificial Sweeteners (Blue, Pink, Yellow) | | Coffee Creamers |

List any food aversions and/or foods you dislike: _____

Do you get noticeably irritated, weak, or lightheaded if you haven't eaten in a while? _____

Do you crave certain foods? _____ What foods? Sweets? Chocolate? Bread/Pasta?
Fried Foods? Alcoholic drinks? Sodas/Diet Sodas? Meat? Other?

Are you:

Under excessive amounts of stress _____ at home _____ at work _____

Physical Stress _____ Mental Stress _____

Exposed to chemicals regularly _____ Type _____

Exposed to smoke regularly _____

How often do you have bowel movements? _____ per day/ week/ month

Urinate? _____ per day

How is your dental health? Prone to Cavities? Gum Disease? Bleeding Gums?

Are your nails weak or brittle? _____

Average Sleep per night? _____

Any sleeping problems? _____

To what extent will you commit to achieving better health?

Little _____ Moderate _____ Major _____ Extreme _____

Is there anything else about either your history or your current condition that you feel is important to mention?
