New Patient Data
Natural Health & Allergy

Name: ____ Date:__________________________
Home Phone: ________________________ Cell Phone: ____________________________________
Address: ____City:________________________
State: ___________ Zip: _______________ Email: ____________________________________
Date of Birth: ______________ Age: __________ Sex: M F Height:______ Weight:______

Responsible Party:
Person Financially Responsible: ____
Employer: _________________________________ Occupation: _____________________________
Employer Address: ______________________________________ City: ________________________
State: ___________ Zip: ________________ work phone: ____________________________
Marital Status: M S D W # of Children, Boys: ______ Girls:_______
Spouse's Name: ___________________________ Employer:_________________________________
Referral name or source: ____

CURRENT CONDITION

Chief Complaint:
____
____
Duration of present condition: ____
What do you believe caused this condition: ____
If due to an injury/accident, please specify: ____

List any known allergies: ____
____

Do any allergic reactions cause anaphylaxis? Yes No
List Reactions: ____
____

Do you smoke? Yes No How many:___________________________________
Do you drink coffee? Yes No How much?______________________________________
Do you drink alcohol? Yes No How much?______________________________________
Do you exercise? Yes No Regularly?______ Infrequently? _________ Seldom?__________
Do you have a pacemaker: Yes No
List all medications you take **prescription and non prescription**:
____
____
____
____

When were you last seen by a physician? ____
For what purpose? ____
Your doctor's name & specialty? ____
Doctor's address: ____
Doctor's phone number: ________________
Diagnosis:____

If you suffer from exhaustion or fatigue, describe how you feel and what time of the day or night you experience these symptoms, including whether they occur daily, occasionally, etc.

____
____
____

Would you say that you are under a lot of stress? Yes No IF yes, explain:

____
____

Do you experience undue worrying, difficulty in concentrating, forgetfulness, failing memory, etc.?____

Female only: Do you experience any pain or discomfort before, during, or after your menstrual cycle? Do you experience any discomfort during the cycle week (regardless of whether you menstruate, are in menopause, or have had surgical removal of all or part of the female reproductive organs or skip your periods periodically)? During the week, are you "grouchy", "irritable", have crying spells, feel uptight, more nervous? Specify any problems: ____
____
____

Are you pregnant now? ______ Date of last menstrual period: __________________________

Do you suffer from any of these symptoms? Check those that apply:

Headaches	Hot Flashes	Blurred Vision	Dizziness
Morning Fatigue	General Fatigue	Labored Breathing	Indigestion
Shortness of Breath	Heartburn	Lump in the throat	Throat Constriction
Numbness	Fainting Spell	Light Headedness	Swelling of the Joints
Loose Stools	Excessive Gas	Insomnia	PMS
Poor Memory	Sexual Impotency	Excessive Perspiration	Dry Skin
Chest Palpitations	Poor Appetite	Excessive Appetite	Night Sweats
Nerves	Depression	Learning Disabilities	Asthma
Chemical Sensitivities	Constipation		

Other ____
List all foods and beverages taken more than three times a week (coffee, sodas, milk, etc.):
____
____

FAMILY HISTORY

Parents Living: Father (age):____________________ Mother (age):_________________
Brothers (ages):___________________ Sisters (ages):_______________________
Is there any history of?
Diabetes: ________ Asthma:________ Cancer:___________ Heart Disease:______
Mental Illness: ________ Lung Disease: ________ Arthritis:____________
Allergies: __________
Any other: Yes No
(Specify) ____

PERSONAL HISTORY

Childhood Diseases: Measles_______ Mumps_______ Chicken Pox:_________
Unusual Childhood Diseases: ____

List any previous injuries (slips, falls, auto accidents, traumatic events) and give dates:
____
____
Have you: had any previous back troubles? Yes No If yes, describe and give dates:
____
____
List any past significant illnesses: ____
____
List all operations (give dates): ____
____

Signed: ____ Date: _______________