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NEW PATIENT HISTORY FORM

Name_____Date_____File No._____
Phone number_____Email_____
Home address_____City_____State_____Zip_____
Date of birth_____Age_____Sex M___F___ Height_____ Weight _____
Employer_____Occupation_____Work phone _____
Work address_____City_____State_____Zip_____
Marrital status M S D W Number of children _____ Boys___ Girls____
Name of spouse_____Referred by_____
Spouse's employer_____Spouse's occupation_____

If patient is a child, please fill out above work information for parent, or whoever is financially responsible.

Medical Insurance: Yes____No_____ Insurance Co. Name_____

Our office does not bill insurance, but if you have a PPO insurance, we can provide a superbill that you can file with your insurance company to get reimbursement directly. We have officially opted out of Medicare, but we do provide a discount for Medicare patients. We will try to use your insurance for lab or imaging tests when possible.

What is your main problem? How long have you had this problem? Please describe in detail.
What do you believe caused this condition?
What are your health goals?

List your medical problems in order of severity and describe any past treatments.
What medications do you take? Please list all medications (prescription and over the counter), vitamins, and herbal supplements. Include doses if you know them.
What foods allergies or sensitivities do you have? Please describe the reaction as well.
What medication allergies or sensitivities do you have? Please describe the reaction as well.
What environmental allergies do you have? Please describe the reaction as well.
Have you ever had an anaphylactic reaction? Yes_____ No_____. If yes, please describe the situation.
What surgeries have you had? Please include the dates or your age at the time of surgery.
Have you ever been hospitalized? For what reason?

Describe any childhood illnesses (for example - childhood asthma).

Do you currently smoke? Yes_____No_____. If yes, how many cigarettes per day? _____
Have you ever smoked in the past? Yes_____No_____. If yes, for how many years_____
Do you drink alcohol? Yes_____No_____. Number of drinks _____per_____week or month
Type of alcohol consumed (beer, wine, hard liquor):_____
Is alcohol an important part of your social life? _____
Do you currently use marijuana? Yes_____No_____Prior marijuana use? Yes_____No_____
Have you ever used other drugs like cocaine, heroin, amphetamines, etc?_____

Please describe any past and present life stressors. For example, include any traumatic events, stress from relationships, stress from work, and financial hardships.

How many hours of sleep do you get per night? _____
Do you have difficulty falling asleep? _____ staying asleep?_____
Do you feel rested upon awakening?_____

How do you relax? What are your hobbies?

Do you exercise? Yes_____No_____
How often? Regularly_____Infrequently_____Seldom_____
What type of exercise?

Regarding your diet:

- I have no dietary restrictions.
- I am vegetarian.
- I am vegan.
- I follow a gluten-free diet.
- I avoid certain foods. Please list the foods you avoid:_____
  _____

What is your current weight?_____ What is your goal weight?_____

Please describe your typical diet as below:

Breakfast:

Lunch:

Dinner:

Dessert:

Snacks:

Beverages:

Do you skip meals? _____Skip breakfast?_____
How often do you eat in restaurants? _____
Do you consume fast food? _____
Do you prepare your own food? _____ Who prepares your food? _____
Do you buy organic foods? _____
Do you avoid GMO (genetically modified) foods?_____
What type of cookware do you use (stainless steel, cast iron, non-stick, ceramic)? _____
How many caffeinated beverages do you drink per day? _____
Do you crave sugar or carbs? _____
Do you do late night snacking?_____
Are you an emotional eater (eat when sad, lonely, depressed or bored)? _____

Who is your primary care doctor?
Office location:
When was your last physical exam?

List your other doctors and health care providers (specialists, acupuncturists, chiropractors, etc).

Health Maintenance Issues:

When was your last:
Colonoscopy_____
Flu shot_____
Tetanus shot_____
Cholesterol checked_____
General blood tests_____

For Women:
When was your last:
Mammogram_____
PAP Smear_____
Last menstrual period_____
Are you pregnant now? Yes____No____

Family History:

Please tell us if your family members have had heart disease, cancer (specify type), diabetes, allergies, autoimmune disease (specify type), lung disease, skin issues, hormonal issues, heavy metal toxicity, or any other health issues.

Mother's age_____Health problems_____
Father's age_____Health problems_____
Sibling's age_____Health problems_____
Sibling's age_____Health problems_____
Sibling's age_____Health problems_____
Sibling's age_____Health problems_____

Any recent camping or travel outside the United States? Where did you go?

Do you have any mechanical devices in your body, like shunts, hearing aids, pacemaker, ear tubes, implants, IUD, etc?

Exposures:

Do you suspect mold exposure in your home or at work?_____
Do you dry clean your clothes?_____
Do you use plastic containers to store your foods?_____
Do you have dental fillings or root canals? _____
Do you read ingredients labels on lotions and cosmetics? _____
Do you use green house cleaning products?_____
Do you suspect toxin exposure from another source? _____

For pediatric patients, please describe vaccine schedule (routine schedule, modified or delayed, or no vaccines) and provide copy of immunization card. Any adverse reaction to any immunization?

Please elaborate on anything else you feel is important for your doctors to know in order to provide the best care.

Please Check any Current or Recent Symptoms:

General
- Weight loss
- Weight gain
- Fatigue
- Fever
- Chills
- Weakness
- Trouble sleeping

Skin
- Hives
- Eczema
- Psoriasis
- Other rash
- Lumps
- Acne
- Itching
- Dry skin
- Color changes in skin
- Hair loss
- Abnormal hair growth
- Premature graying
- Dandruff
- Nail changes

Head, Ears, Nose
- Headaches
- Head injury
- Sensitivity to light
- Sensitivity to sounds
- Decreased hearing
- Ringing in the ears (tinnitus)
- Earache
- Ear drainage
- Problems with vision
- Watery or itchy eyes
- Floaters in vision
- Glaucoma
- Cataracts
- Nasal congestion
- Postnasal drip
- Nose bleeds
- Sinus pain or infections
- Sneezing
- Dry mouth
- Hoarseness
- Thrush
- Mouth sores
- Bad breath
- Dental decay
- Bleeding gums
- Gum disease
- Sore throat
- Hoarseness

Neck Symptoms
- Lumps in neck
- Swollen glands
- Pain in neck
- Stiffness in neck

Breasts
- Breast lumps
- Breast pain
- Breast discharge

Lungs
- Asthma
- Dry cough
- Productive cough
- Coughing up blood
- Shortness of breath at rest
- Wheezing
- Painful breathing

Heart
- Chest pain or discomfort
- Chest tightness
- Irregular heart beat
- Shortness of breath with activity
- Difficulty breathing when lying down
- Swelling in legs
- Sudden awakening from sleep with shortness of breath
- High blood pressure
- Low blood pressure

GI tract
- Difficulty swallowing
- Heartburn
- Increased appetite
- Decreased appetite
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Blood in stools
- Yellow skin or eyes
- Abdominal pain
- Bloating
- Hemorrhoids

Urinary Tract
- Frequent urination
- Burning with urination
- Incontinence
- Blood in the urine
- Prostate abnormalities

Reproductive
- Vaginal or penile discharge
- Sores in genital region
- Sexually transmitted diseases
- Yeast infection
- Pain with intercourse
- Decreased libido
- PMS (premenstrual syndrome)
- Infertility
- Irregular menses
- Heavy menses
- Painful menses

Vascular
- Calf pain when walking
- Leg cramping
- Varicose veins

Musculoskeletal
- Muscle pain
- Joint pain
- Stiffness
- Back pain
- Swelling of joints
- Injury to joints
- Redness of joints
- Hip pain
- Knee pain
- Shoulder pain

Neurologic
- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor
- Migraine headaches
- Brain fog
- Daytime drowsiness

Hematologic
- Anemia
- Easy bruising
- Cuts heal slowly
- Bleeding problem

Hormonal
- Intolerance to heat
- Intolerance to cold
- Frequent urination
- Excess thirst
- Hot flashes

Mental Health
- Depression
- Anxiety
- Memory loss
- Suicidal thoughts
- Bipolar disorder
- Attention deficit
- Anger outbursts
- Compulsive behavior
- Emotional imbalances
- Hyperactive
- Phobias

Other
- Craving for sweets
- Craving for salty food
- Craving for spices
- Crave coffee or caffeine
- Crave sour or bitter