New Patient Data
Natural Health & Allergy

Name: ____ Date:___________________
Home Phone: _____________________ Cell Phone: ____________________________
Address: ____City:_________________
State: __________ Zip: ______________ Email: ___________________________
Date of Birth: ___________________ Age:_____________ Sex: M F (circle one)
Height:___________ Weight:____________

If patient is a minor, complete remainder of section for financially responsible person.

Employer: ______________________________ Occupation: _______________________
Employer Address: ___________________________________ City: _________________
State: __________ Zip: _______________ work phone: _____________________
Marital Status: M S D W (circle one) # of Children, Boys: ____ Girls:________
Name of Spouse: _______________________________ Referred by:________________
Spouse's Employer: ____
Spouse's Employer Address: ____
Person Financially Responsible: ____

CURRENT CONDITION

Chief Complaint: ____

____

____

Duration of present condition: ____
What do you believe caused this condition? ____

List any known allergies: ____

____

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

If due to an injury/accident, please specify: ____
Do you smoke? Yes or No How many:___________________________________
Do you drink coffee? Yes or No How much?___________________________________
Do you drink alcohol? Yes or No How much?___________________________________
Do you take any drugs/medications?____

____

Do you take vitamins/supplements? Yes or No
List names: ____
Do you exercise? Yes or No Regularly?______ Infrequently? ________ Seldom?_________
Do you have a pacemaker? ________

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 or 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
_____ Palpitation of the Chest	______ 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 or 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 or No If yes, describe and give dates:

____

List any past significant illnesses: ____

List all operations (give dates): ____

Signed: ____ Date: _______________