New Creation Naturopathic Center

Dr Katrin Goto ND, R.Ph www.drkatringoto.com

1029 109th Ave SE

Bellevue, WA 98004

425-922-9169

###### NEW PATIENT HISTORY FORM

**To our new patients:** To help us establish you with our Naturopathic practice, please provide us with your complete health history including all physical and mental symptoms.

### Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Personal History

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_(mm/dd/yyyy) Age\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (City & Country)

Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (inches) Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(lbs.)

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your PCP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** Example: Food, Pollens, Odors, Medicines, Pets etc… **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chief Complaint/ reasons for this CONSULTATION:** (if possible, rank in terms of importance to you)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional problems or concerns you would like to be addressed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Note: we may not be able to address every problem during the course of one treatment.

# **Current Medications Dose Times / Day / Prescribers**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Current Herbs / Vitamins/ Homeopathy/ Supplements Dose Times / Day/ Prescribers

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\***  Note: If additional space is need, add to last page.

##### PAST MEDICAL, SURGICAL & TRAUMA HISTORY Patient’s Name:

List prior illness, injury, hospitalization, surgery, and/or trauma:

**Reason: Date/Month and Year**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL AND FAMILY HISTORY**

Check those that apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yourself | Mother | Father | Grandparents | Sister/ Brother | Spouse | Children |
| AIDS |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |
| Alzheimer’s |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |  |  |
| Bleeding Disorder |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |  |  |
| COPD |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Emphysema |  |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |
| Heart Trouble |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| IBS |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |
| Migraine Headaches |  |  |  |  |  |  |  |
| Pneumonia |  |  |  |  |  |  |  |
| Prostate Cancer |  |  |  |  |  |  |  |
| Sickle Cell Anemia |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Suicide |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |
| Ulcers |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

**SOCIAL HISTORY (**check those that apply): **Patient’s Name:**

**Marital status: Education level completed: Memories of your childhood Do You Find Your Life**

single  high school  Mostly happy  Generally Unsatisfactory

married  college  Mostly painful  Too Demanding

divorced  professional school  Normal  Boring

widowed  other:  don’t recall  Satisfactory

**Living arrangement:**

alone  family  roommate  significant other

children (list sex/ages):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major stresses in last 2 years  Money  Job  Marriage  Home Life  Children

other stress\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pertinent travel history:**(out of USA, epidemic areas)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE / SELF-CARE ISSUES**

Do you smoke cigarettes?  YES  NO If yes, how many? #\_\_\_\_\_yrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ packs per day

Did you ever smoke?  YES  NO If yes, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol?  YES  NO If yes, how much? Type\_\_\_\_\_\_\_\_\_ & \_\_\_\_\_\_\_\_\_ drinks per week

Do you drink caffeine beverages?  YES  NO If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs?  YES  NO If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you manage stress well?  YES  NO  NOT SURE  NEED HELP

Do you exercise regularly?  YES  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you enjoy your job?  YES  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you allow time to unwind and relax?  YES  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sleep soundly?  YES  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your sex life?  YES  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your social life?  YES  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your spiritual life?  YES  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your diet healthy enough?  YES  NO  NOT SURE  NEED HELP

Typical breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical snacks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Devices

**Do You Use:**

\_\_\_Eyeglasses \_\_\_\_\_\_Contact Lens \_\_\_\_\_\_Hearing Aid \_\_\_\_\_\_Dentures

\_\_\_Brace (Neck, Back) \_\_\_\_\_\_ Pacemaker \_\_\_\_\_\_ IUD, Diaphragm \_\_\_\_\_\_Artificial Limbs

## REVIEW OF SYSTEMS Patient’s Name:

Check any symptoms that currently apply to you:

Constitutional Mouth, Throat Muscles, Bones & Joints Digestion & Intestines

\_\_\_ poor appetite \_\_\_ tongue discoloration \_\_\_\_neck pain \_\_\_\_indigestion

\_\_\_ fevers \_\_\_ bad breath \_\_\_\_back pain \_\_\_\_belching/ flatulence

\_\_\_ chills \_\_\_ teeth problems \_\_\_\_muscle pain \_\_\_\_difficulty swallowing

\_\_\_ food craving \_\_\_ grinding teeth \_\_\_\_ painful joints: R\_\_L\_\_ \_\_\_\_heartburn/ ulcer

\_\_\_ weight loss \_\_\_ tonsillitis/ adenoids \_\_\_\_shoulder \_\_\_\_elbow \_\_\_\_nausea

\_\_\_ weight gain \_\_\_ facial pain \_\_\_\_hip\_\_\_\_ knee \_\_\_ankle \_\_\_\_ liver trouble

\_\_\_ fatigue \_\_\_ sore throat \_\_\_\_wrist \_\_\_\_\_fingers \_\_\_\_ vomiting

**Eyes** \_\_\_ ulceration tongue \_\_\_\_joint swelling \_\_\_\_ diarrhea

\_\_\_ eye pain \_\_\_ gum bleeding \_\_\_\_muscle weakness \_\_\_\_ cramping bowels

\_\_\_ blurred vision **Heart & Circulation \_\_\_\_**muscle cramps \_\_\_\_ food allergies

\_\_\_ poor vision\_\_\_day \_\_\_\_chest pain **Skin, Hair \_\_\_\_**constipation

\_\_\_ poor vision\_\_\_night \_\_\_\_ lightheadedness \_\_\_\_ psoriasis \_\_\_\_ abdominal pain

\_\_\_ wear corrective lenses \_\_\_ palpitations \_\_\_\_ warts \_\_\_\_rectal pain/ itching

\_\_\_ near\_\_\_\_far sighted \_\_\_\_ cold hands/feet \_\_\_\_ freckles \_\_\_\_ hemorrhoids/ piles

\_\_\_ other \_\_\_\_ fainting \_\_\_\_ itching, hives \_\_\_\_ blood in stool

### Ears, Nose \_\_\_\_ swelling feet \_\_\_\_ hair loss Urine, Kidney, Bladder

\_\_\_ ringing ears \_\_\_\_ blood clots \_\_\_\_ dry skin, eczema \_\_\_\_painful urination

\_\_\_ nosebleed/polyp \_\_\_\_ varicose veins **Nerves, Movement, Brain \_\_\_\_**wake up to urinate

\_\_\_postnasal drip **Breathing & Lungs \_\_\_\_** seizures **\_\_\_\_**kidney stones

\_\_\_sinus problems \_\_\_\_\_shortness of breath \_\_\_\_\_nerve pain \_\_\_\_ loss of control

\_\_\_trouble with taste/smell \_\_\_\_\_wheezing or asthma \_\_\_\_\_poor balance \_\_\_\_ frequent urination

\_\_\_poor hearing \_\_\_\_\_repeated colds/ flu \_\_\_\_\_poor coordination \_\_\_\_ sudden urging

\_\_\_earaches/ infections \_\_\_\_\_ cough dry/ irritating \_\_\_\_\_tremors or shaking \_\_\_\_ blood/pus urine

\_\_\_sneezing/ discharges \_\_\_\_\_headaches \_\_\_\_urine infection UTI

### Immune System Sexual Organs Women Reproductive

**\_\_\_\_**too many infections \_\_\_\_ sores on genitals \_\_\_\_\_ pelvic pain \_\_\_\_age period started

\_\_\_\_allergies to food \_\_\_\_ lumps or swelling \_\_\_\_\_ vaginal discharge \_\_\_\_ # of pregnancies

\_\_\_\_allergies to environment \_\_\_\_ erection problems \_\_\_\_\_ painful periods \_\_\_\_# abortions

\_\_\_ other concerns \_\_\_\_ premature ejaculation \_\_\_\_\_premenstrual syndrome \_\_\_\_# miscarriages

### Blood System \_\_\_\_pain with sex \_\_\_\_\_ hot flashes \_\_\_\_# live births

\_\_\_\_lymph gland swelling \_\_\_\_infertility \_\_\_\_\_ itching or soreness \_\_\_children currently living

\_\_\_\_anemia \_\_\_\_repeated infections \_\_\_\_\_irregular menses \_\_\_age menopause \_\_\_ \_\_\_\_easy bruising \_\_\_\_aversion to sex \_\_\_\_\_leucorrhoea \_\_\_past infertility

Mind Symptoms Thermal State

\_\_\_\_memory \_\_\_hot

\_\_\_\_temper/anger \_\_\_chilly

\_\_\_\_emotional

\_\_\_\_sleep

**Additional Symptoms** --\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF NOT NOTED IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/OR NON-PERTINENT.**

## HEALTH SCREENING HISTORY Patient’s Name:

List the date of your most recent test, imaging or exam.

Mammogram \_\_\_\_\_\_\_\_\_ Pap Smear\_\_\_\_\_\_\_\_\_\_ Self Breast Exam \_\_\_\_\_\_\_\_\_\_\_Breast Exam by your PCP\_\_\_\_\_\_\_\_\_\_\_\_

Blood test for Cholesterol \_\_\_\_\_\_\_\_\_ Blood Sugar \_\_\_\_\_\_\_\_Other Blood tests\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunizations: Tetanus\_\_\_\_\_\_\_\_\_\_Hepatitis\_\_\_\_\_\_\_\_\_\_MMR\_\_\_\_\_\_\_\_\_\_\_\_Flu Shot\_\_\_\_\_\_\_Covid\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test for Blood in stool\_\_\_\_\_\_\_ Rectal Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_The Prostate\_\_\_\_\_\_\_\_\_ Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self Exam Testicle \_\_\_\_\_\_\_\_\_\_\_Testicle Exam by Professional\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Anatomy\Procedure | X-ray | MRI | CT Scan | Ultrasound | Bone Scan | EKG | EEG |
| Back |  |  |  |  |  |  |  |
| Brain |  |  |  |  |  |  |  |
| Chest |  |  |  |  |  |  |  |
| Colon |  |  |  |  |  |  |  |
| Extremities (Arm/Leg) |  |  |  |  |  |  |  |
| Gallbladder |  |  |  |  |  |  |  |
| Kidney |  |  |  |  |  |  |  |
| Neck |  |  |  |  |  |  |  |
| Pelvis |  |  |  |  |  |  |  |
| Stomach |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

**A complete case record will be analyzed for Naturopathic treatment. This is a confidential record and will be kept in the office. Information contained here will not be released to anyone without your authorization to do so.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/ Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Residential Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Numbers: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave voicemail?Y No**

**Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact (name, phone #& relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Financial Policies and Disclosures**

***Please read, initial each item and sign at the bottom***

1. Dr. Goto does not bill all insurance plans. At the time of visit, please request a receipt to submit to your insurance.
2. The fee for our services is $300 per hour. The First office visit lasts approximately 1-2 hrs. The consequent appointments are 1 to 1&1/2 hours. The appointments are tailored to address your needs as an individual. You receive personally designed remedies and treatments for your specific needs. Some patients prefer longer time with the physician and some prefer shorter visits. I welcome your input at the start of our meeting, so all time related concerns are addressed & tailored into your treatment plan. All consultations are to be paid at the time of service.
3. Please provide the office with 48 hour notice, if you are un-able to keep your appointment. This time has been set aside for you to address your individual needs. Cancelation without 48 hour notice will be subject to a $175 no show fee.
4. Phone/ email consultations with prior arrangements are priced at $300 per hour ($75 per 15 minutes).
5. Dr. Goto holds an active Pharmacist license to practice Pharmacy in the State of Washington. Bring your Prescription medicines to the appointment and have all your questions covered.
6. There are no narcotics and no cannabis on the premises.
7. **Consent for treatment:** By signing this, I give New Creation Naturopathic Center permission to provide me with all their services and products at the rate stated above.
8. **Release of information:** *By signing this, I give this office permission to release information required by law or insurance regulation to insurance agencies involved in my case. This* ***does not*** *give permission for any other release of information by this office, which has not been authorized by me.*

*I have read, clearly understood, and agreed to the above policies*

Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent / Guardian signature, if under 18 years old)