New Creation Naturopathic Center
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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:_____

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 HISTOR Y Patient Name:

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

Date/Month and Year:_____

Reason:

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 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 Name:

Check any symptoms that currently apply to you:

Constitutional
- ☐ poor appetite
- ☐ fevers
- ☐ chills
- ☐ food craving
- ☐ weight loss
- ☐ weight gain
- ☐ fatigue

Eyes
- ☐ eye pain
- ☐ blurred vision
- ☐ poor vision ___day
- ☐ poor vision ___night
- ☐ wear corrective lenses
- ☐ near sighted
- ☐ far sighted
- ☐ other

Ears, Nose
- ☐ ringing ears
- ☐ nosebleed/polyp
- ☐ postnasal drip
- ☐ sinus problems
- ☐ trouble with taste/smell
- ☐ poor hearing
- ☐ earaches/infections
- ☐ sneezing/discharge

Mouth, Throat
- ☐ tongue discoloration
- ☐ bad breath
- ☐ teeth problems
- ☐ grinding teeth
- ☐ tonsillitis/ adenoids
- ☐ sore throat
- ☐ facial pain
- ☐ ulcerated tongue
- ☐ gum bleeding

Heart & Circulation
- ☐ chest pain
- ☐ lightheadedness
- ☐ palpitations
- ☐ cold hands/feet
- ☐ fainting
- ☐ swelling feet
- ☐ blood clots
- ☐ varicose veins

Breathing & Lungs
- ☐ shortness of breath
- ☐ wheezing or asthma
- ☐ repeated colds/flu
- ☐ cough dry/irritating

Muscles, Bones & Joints
- ☐ neck pain
- ☐ back pain
- ☐ muscle pain
- ☐ painful joints: R__ L__
- ☐ shoulder
- ☐ elbow
- ☐ hip
- ☐ knee
- ☐ ankle
- ☐ wrist
- ☐ fingers
- ☐ joint swelling
- ☐ muscle weakness
- ☐ muscle cramps

Skin, Hair
- ☐ psoriasis
- ☐ warts
- ☐ freckles
- ☐ itching, hives
- ☐ hair loss
- ☐ dry skin, eczema

Nerves, Movement, Brain
- ☐ seizures
- ☐ nerve pain
- ☐ poor balance
- ☐ poor concentration
- ☐ tremors or shaking
- ☐ headaches

Digestion & Intestines
- ☐ indigestion
- ☐ belching/ flatulence
- ☐ difficulty swallowing
- ☐ heartburn/ ulcer
- ☐ nausea
- ☐ liver trouble
- ☐ vomiting
- ☐ diarrhea
- ☐ cramping bowels
- ☐ food allergies
- ☐ constipation
- ☐ abdominal pain
- ☐ rectal pain/ itching
- ☐ hemorrhoids/ piles
- ☐ blood in stool

Urine, Kidney, Bladder
- ☐ painful urination
- ☐ wake up to urinate
- ☐ kidney stones
- ☐ loss of control
- ☐ frequent urination
- ☐ sudden urging
- ☐ blood/pus urine
- ☐ urine infection UTI

Immune System
- ☐ too many infections
- ☐ allergies to food
- ☐ allergies to environment
- ☐ other concerns

Blood System
- ☐ lymph gland swelling
- ☐ anemia
- ☐ easy bruising

Mind symptoms
- ☐ memory
- ☐ temper/anger
- ☐ emotional
- ☐ sleep

Sexual Organs
- ☐ sores on genitals
- ☐ lumps or swelling
- ☐ erection problems
- ☐ premature ejaculation
- ☐ pain with sex
- ☐ infertility
- ☐ repeated infections
- ☐ aversion to sex

Thermal State
- ☐ hot
- ☐ chilly

Women
- ☐ pelvic pain
- ☐ vaginal discharge
- ☐ painful periods
- ☐ premenstrual syndrome
- ☐ hot flashes
- ☐ itching or soreness
- ☐ irregular menses
- ☐ leucorrhoea

Reproductive
- ___ age period started
- ___ # of pregnancies
- ___ # of abortions
- ___ # of miscarriages
- ___ # of live births
- ___ # of children currently living
- ___ age menopause
- ___ past infertility

Additional Symptoms --

_____

_____

_____

_____

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

HEALTH SCREENING HISTORY Patient Name:

List the date of your most recent test or exam.

Mammogram _____ Pap Smear_____ Self Breast Exam _____Breast Exam by Doctor_____

Blood test for Cholesterol _____ Blood Sugar _____Other Blood tests_____

Immunizations: Tetanus_____Hepatitis_____MMR_____Flu Shot_____

Test for Blood in stool_____ Rectal Exam _____Feeling the Prostate_____ Scope Lower Bowel_____

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: _____

_____

Phone Numers: (Home) _____ **(Cell)** _____

Email _____

Emergency Contact (name and phone number): _____

_____

_____