

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Nature Cures Clinic New Patient Intake Form

Name _____ Date _____

Home Phone _____ DOB _____

What are the primary health concerns? List as many as you can and in order of importance.

What are the primary expectations you have for your visit today at our Clinic?

Is this your first visit to a Naturopathic Physician? _____ or Acupuncturist? _____

Who referred you? _____

General Information:

Height _____

When during the day is your energy and alertness best? _____ Worst _____

Blood Type _____

Primary interests and hobbies _____

Primary form of exercise, if any _____

How Often _____

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Dear New Patient:

- a. Please **read** and **fill in** all of the information that pertains to you.
- b. On pages 2 through 11, under each category, **check all** symptoms that you experience either *acutely or chronically*. Use the column on the left side of the page. The columns to the right of the page will be used by your physician at re-exam.
- c. **Add** and **total** all of the boxes you checked.
- d. **Date** today's day.

TEST	DATE	TEST RESULTS
<input type="checkbox"/> Physical		
<input type="checkbox"/> Cholesterol		
<input type="checkbox"/> Prostate		
<input type="checkbox"/> Mammography		
<input type="checkbox"/> Pap Smear		
<input type="checkbox"/> Blood (which test?)		
<input type="checkbox"/> HIV/STD		
<input type="checkbox"/> Other		

<i>Please indicate if you have (or have been tested for) any of the following:</i>			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Vein condition
<input type="checkbox"/> Heart disease	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Chicken pox
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Polio
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Measles	<input type="checkbox"/> Nervous disorder	<input type="checkbox"/> Migraines
<input type="checkbox"/> Meningitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Monucleosis	<input type="checkbox"/> Other liver illnesses
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High fever	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other heart illnesses
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Other kidney illnesses
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mumps	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other lung illnesses

IMMUNIZATIONS?

SURGERIES?

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5. Liver, Spleen, Heart Function:

- Dizziness
- See floating black spots

Total Boxes Checked:
Date: _____

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____

6. Heart Function:

- Anxiety
- Sores on tip of tongue
- Restlessness
- Mental confusion
- Alternating chest to shoulder pain
- Frequent dreams
- Wake up feeling tired
- Coffee? How much per week? _____

Total Boxes Checked:
Date: _____

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____

7. Spleen Function:

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas

spleen function continued next page...

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.

Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____

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13. Liver, Gall Bladder Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.

	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
<input type="checkbox"/> Alternating diarrhea & constipation						
<input type="checkbox"/> Chest pain						
<input type="checkbox"/> Tight sensation in the chest						
<input type="checkbox"/> Bitter taste in the mouth						
<input type="checkbox"/> Anger easily						
<input type="checkbox"/> Depression						
<input type="checkbox"/> Frustration						
<input type="checkbox"/> Irritability						
<input type="checkbox"/> Skin rashes						
<input type="checkbox"/> Headache at the top of the head						
<input type="checkbox"/> Tingling sensation						
<input type="checkbox"/> Numbness						
<input type="checkbox"/> Muscle twitching						
<input type="checkbox"/> Muscle cramping						
<input type="checkbox"/> Muscle spasms						
<input type="checkbox"/> Seizures						
<input type="checkbox"/> Convulsions						
<input type="checkbox"/> Lump in the throat						
<input type="checkbox"/> Neck tension						
<input type="checkbox"/> Shoulder tension						
<input type="checkbox"/> Limited range-of-motion (neck)						
<input type="checkbox"/> Limited range-of-motion (shoulder)						
<input type="checkbox"/> How much alcohol / day? _____						
<input type="checkbox"/> Recreational drugs (which? _____)						
<input type="checkbox"/> High-pitched ringing in ears						
<input type="checkbox"/> Gall stones (history or current)						
<input type="checkbox"/> STD's (which? _____)						
<input type="checkbox"/> Unable to adapt to stress						
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total	<input type="checkbox"/> Total
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____

