NATUROPATHIC NEW PATIENT HEALTH HISTORY

Patient's Name:

_____
Last Middle First

Date of Birth: _____ Age: _____ Male/Female (circle)

Address:

_____

City: _____State: _____Zip Code: _____

Contact Information (Please circle preferred number for contacting you):

Home telephone: _____Work telephone: _____
Cell phone: _____Email address: _____

Please check box regarding how HEAL Natural Medicine may contact you:

☐may leave a detailed message with identifying information.
☐may only state who is calling and contact phone number.

Occupation: _____

Emergency contact: _____Relationship: _____
Emergency contact telephone number: _____

How did you hear about us?

_____

Are you currently receiving health care? (Circle) Y N
If yes, please provide contact information below:
Name of provider/ clinic:

_____
Address:

_____
If no, why have you discontinued care?

_____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Dr. Bridget Anderson, NMD to release information necessary to secure payment.

Signature: _____ Date: _____

PERSONAL HEALTH HISTORY

When did you last visit a doctor's office, medical clinic, or hospital? Please explain:

_____

_____

What hospitalizations or surgeries have you had? Please list by most recent:

_____

_____

_____

What are your primary health concerns? Please list in the order of their importance to you.

1) _____

Past treatment: _____

2) _____

Past treatment: _____

3) _____

Past treatment: _____

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

_____

_____

ALLERGIES: Are you aware of any allergies to foods, drugs, or other environmental allergens (cats, mold, dust)? If yes, please explain:

_____

_____

MEDICATIONS AND SUPPLEMENTS:

Do you take or use any of the following?

☐Pain relievers (aspirin, ibuprofen)
☐Diet pills, appetite suppressants
☐Cortisone (pills or cream)
☐Thyroid medication
☐Antacids
☐Laxatives
☐Sleeping pills
☐Antibiotics
☐Digestive Aids
☐Anti-depressants
☐Tranquilizers
☐Birth control pills

Please list any prescription medications, over-the-counter medications, or other supplements you are taking:

_____

_____

_____

GENERAL:

Height: _____ Current Weight: _____lbs. Weight 1 year ago: _____lbs.

Maximum weight: _____lbs. When? _____

ENERGY: Average daily energy: (circle)

1 2 3 4 5 6 7 8 9 10

Generally, what time of day is your energy the best? _____ The worst? _____

STRESS:

Current level of stress: (circle) 1 2 3 4 5 6 7 8 9 10

FAMILY HISTORY:

Mother

Age:_____ Health conditions: _____

Age at death (if deceased)_____ Cause of death_____

Father

Age:_____ Health conditions: _____

Age at death (if deceased)_____Cause of death _____

Sibling(s)

Age(s):_____ Health conditions: _____

Age at death (if deceased)_____ Cause of death _____

Spouse/Partner

Age:_____ Health conditions: _____

Age at death (if deceased)_____Cause of death_____

Child/Children

Age(s):_____ Health conditions: _____

Age at death (if deceased)_____ Cause of death _____

Do you have a family history of any of the following diseases or conditions? *When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.*

☐Anemia	☐Gallbladder disease	☐Multiple Sclerosis
☐Arthritis	☐Hay fever	☐Parkinson's
☐Asthma	☐Heart Disease	☐Alzheimer's
☐Cancer	☐High blood pressure	☐Stroke
☐Diabetes	☐Kidney Disease	☐Thyroid disorders
☐Epilepsy	☐Mental Illness	

Please list other significant family medical history not listed above:

_____

_____

CHILDHOOD ILLNESSES:

☐Diphtheria	☐Chickenpox	☐Meningitis
☐Rheumatic Fever	☐Scarlet Fever	☐Polio
☐Measles	☐Rubella	☐Other:_____
☐Chickenpox	☐Mumps	
☐Diphtheria		

IMMUNIZATIONS:

☐Measles/Mumps/Rubella	☐Meningitis	☐Flu
☐Tetanus	☐Chickenpox	☐Diphtheria
☐Polio	☐Pertussis	☐Other _____