New Patient Basic Information

NAME:

ADDRESS:

PRIMARY PHONE:
Is this your Home/cell/work phone?

SECONDARY PHONE:
Is this your Home/cell/work phone?

DATE OF BIRTH:

OCCUPATION:

EDUCATION:

EMAIL ADDRESS:

Circle one: Single Married Life-partner Divorced Widowed

Circle one: Female Male Transgender

Please explain your main concern(s) prompting you to consult with us:

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MEDICAL HISTORY:

Recurring problems:

Major illnesses and/or hospitalizations:

Surgeries:

Current medications (attach list if needed):

Current supplements (attach list if needed):

Recent physicians and other medical professionals:

Recent tests and results (bring copies of bloodwork or reports if possible):

Allergies to medications:

Environmental allergies:

Toxic exposure history:

Trauma (physical and/or emotional):

What are your treatment goals (what do you hope to accomplish as a result of working with us)?

FAMILY HISTORY:

Mother's age:_____ or deceased at age:_____Medical problems:

Father's age:_____ or deceased at age:_____ Medical problems:

# of Sisters:_____ ages: _____ Medical problems:

# of Brothers:_____ ages: _____ Medical problems:

# of Children: _____ ages:_____ Medical problems:

Others, if significant (grandparents, aunts/uncles, etc.):

SOCIAL HISTORY:

Hobbies:

Use of tobacco (now and in the past):

Menthol cigarette use now? YES NO

Caffeine intake (coffee, tea, energy drinks):

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Use of alcohol (now and in the past):

Recreational drug use (now and in the past):

Are you concerned about your use of alcohol or other substances?

Do you get regular physical activity/exercise?

Do you have concerns about your diet?

Do you follow any particular diet or have dietary restrictions (vegan, vegetarian, paleo, gluten-free, dairy-free, soy-free, etc.)?

Do you feel safe in your home environment?

TESTING:

When was your most recent:

_____ Bloodwork
_____Colonoscopy/Cologuard
_____Annual physical
_____Vitamin D screening
_____Pap/pelvic (women)
_____Rectal/prostate exam (men)
_____Mammogram/breast thermogram
_____Chest CT (smokers, former heavy smokers)
_____Vaccinations

Please bring copies of any blood-work and/or test results from the last 1-2 yrs.

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