

New Patient Paperwork

Name:				Date:	
Address:			Country:		
City:		State:		Zip/Postal Code:	
Home Phone:		Work Phone:		Fax:	
E-mail:			Cell Phone:		
Please mark your preference for follow up communication from our office: <input type="checkbox"/> Email <input type="checkbox"/> Phone					
Age:	Birth date:		Sex: M F	Status: M S W D	No. Children:
Occupation:			Employer:		Years Employed:
Spouse's Name:			Occupation:		Employer:
Person responsible for this account:				Referred by:	
What are your major complaints?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you really felt good?					

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.

Patient's Signature: _____

Date: _____

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Height _____ Weight _____ Blood Pressure (if known) _____ % Body Fat (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins?

Please list (attach sheet if necessary)

2. In the past, have you used birth control pills and/or antibiotics?

a. For how long? _____

3. If you have fillings, please list material(s) used:

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia

Frequent Headaches

Skin condition

Arthritis

Heartburn

Thyroid condition

Asthma

High blood pressure

Unexplained weight change

Chest pains

High cholesterol

Chronic cold/flu symptoms

Hypoglycemia

Chronic fatigue

Kidney problems

Depression

Liver problems

Diabetes

Osteoporosis

5. How much sleep do you get each night on average?

6. Do you have any food allergies, sensitivities or restrictions?

7. Do you smoke, drink alcohol or use recreational drugs?

a. How much, how often?

b. How often do you drink caffeinated beverages?

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.):

9. Are there foods that you eat on a daily basis, almost daily basis?

a. Do you “miss” these foods if you do not eat them?

10. Write briefly about your weight gain/loss history:

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity:

12. What methods have you tried to lose/gain weight?

13. How is your energy level?

a. Are there times in the day that you feel best?

_____ **worst?** _____

14. Are you happy in your life right now?

15. What are your main sources of stress?

16. How do you deal with your stress?

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes _____ No _____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes _____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes _____ No _____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes _____ No _____

e. Now and then I think I am a secret eater. Yes _____ No _____

f. At a restaurant, I eat too much bread before the meal is served. Yes _____ No _____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes _____ No _____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No _____

i. I feel shaky if I don't eat on time or if I don't snack. Yes _____ No _____

18. Check off any of the following that have applied to you within the last year:

_____ Do you feel nauseous?

_____ Do you have abdominal/intestinal pain?

_____ Do you have bloating?

_____ Do you get bloated after meals?

_____ Do you get heartburn?

_____ Do you have diarrhea?

_____ Do you have constipation?

_____ Do you travel outside of the U.S.?

_____ Do you have gas?

_____ Are your stools compact/hard to pass?

_____ Do you belch following meals?

_____ Do you have gurgles in your stomach?

_____ Do your bowel movements alternate between constipation and diarrhea?

19. In your estimation, how physically fit are you right now?

Unfit_____ Below average_____ Average _____ Above average_____ Very fit_____

20. How often do you exercise?

a. What is your regime?

21. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

22. What are your fitness goals? (Check all that apply)

_____ General fitness endurance

_____ Muscle toning

_____ Weight loss/maintain weight

_____ Muscle strengthening

_____ Osteoporosis prevention

_____ Muscular coordination/balance

_____ Specific sport enhancement

Other_____

_____ Flexibility

23. Surgeries, starting with most recent:

24. Hospitalizations:

25. Briefly describe where you have lived since childhood:

26. What is your heritage? (Irish, German, Spanish, etc.)

27. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:

Now Past Satisfactory
Now Past Boring
Now Past Demanding
Now Past Unsatisfactory

Do you worry over:

Now Past Home life
Now Past Marriage
Now Past Children
Now Past Job
Now Past Income
Now Past Money problems

Do you often:

Now Past Feel depressed
Now Past Have anxiety

Do you often:

Now Past Have irrational fears
Now Past Feel upset
Now Past Feel things go wrong
Now Past Feel shy
Now Past Cry
Now Past Feel inferior

Have you:

Now Past Seriously considered suicide
Now Past Attempted suicide