



### Confidential New Patient Form

Name (last, first, m.): \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Referred By: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Co. (primary): \_\_\_\_\_ Policy No: \_\_\_\_\_

Insurance Co. (secondary): \_\_\_\_\_ Policy No: \_\_\_\_\_

Social Security No: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's Social Security No: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: (\_\_\_\_) \_\_\_\_\_

Please check the appropriate box:  single  married  partnered  divorced  widowed  separated

Please list any current symptoms you may have in order of importance:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

Surgeries (year/type): \_\_\_\_\_

Serious illnesses and/or accidents (year/cause): \_\_\_\_\_

#### Medications (please list all supplements, prescriptions and non-prescription drugs):

Name of medication	Taken how often?	When did you start/stop taking it?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other medications you have taken in the past five years: \_\_\_\_\_

#### Habits: Never Rarely Occasionally

Coffee:    Weekly/Daily Amount: \_\_\_\_\_

Black tea:    Weekly/Daily Amount: \_\_\_\_\_

Tobacco:    Weekly/Daily Amount: \_\_\_\_\_

Alcohol:    Weekly/Daily Amount: \_\_\_\_\_

Laxatives:    Weekly/Daily Amount: \_\_\_\_\_

Aspirin:    Weekly/Daily Amount: \_\_\_\_\_

Drugs:    Weekly/Daily Amount: \_\_\_\_\_

Other:    Weekly/Daily Amount: \_\_\_\_\_

Name/location/date of last doctor visited: \_\_\_\_\_

Other practitioners seen: \_\_\_\_\_

Do you eat a special diet? \_\_\_\_\_

Work: \_\_\_\_\_ hours/week Sleep: \_\_\_\_\_ hours/week Exercise: \_\_\_\_\_

General quality of sleep: \_\_\_\_\_ Type of exercise: \_\_\_\_\_

Are you willing to change your living habits to improve your health? \_\_\_\_\_

Date of last complete checkup: \_\_\_\_\_ Practitioner: \_\_\_\_\_

Please list chemicals, metals, dusts, or fumes you are repeatedly exposed to, or which you were repeatedly exposed to in the past (please include dates): \_\_\_\_\_

Do you react to pollens? \_\_\_\_\_ To foods? (what type?) \_\_\_\_\_

Do you use a contraceptive?  yes  no If yes, what type? \_\_\_\_\_

If any family members have had any of the following, please check:

- |  |                                    |  |  |
|--|------------------------------------|--|--|
| <input type="checkbox"/> allergies         | <input type="checkbox"/> blindness | <input type="checkbox"/> heart disease       | <input type="checkbox"/> kidney disease          |
| <input type="checkbox"/> alcoholism        | <input type="checkbox"/> cancer    | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> nervous/mental disorder |
| <input type="checkbox"/> asthma            | <input type="checkbox"/> diabetes  | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> tuberculosis            |
| <input type="checkbox"/> bleeding tendency | <input type="checkbox"/> epilepsy  | <input type="checkbox"/> hypoglycemia        |  |

Other (please describe) \_\_\_\_\_

Have you had any of the above? \_\_\_\_\_ If yes, what? \_\_\_\_\_

Check if you have ever had:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> back trouble          | <input type="checkbox"/> liver disorder    | <input type="checkbox"/> thyroid disorder   |
| <input type="checkbox"/> cataracts             | <input type="checkbox"/> loss of sex drive | <input type="checkbox"/> trouble with sleep |
| <input type="checkbox"/> gall bladder disorder | <input type="checkbox"/> stroke            | <input type="checkbox"/> ulcers, peptic     |

Other (please describe) \_\_\_\_\_

Living situation:  alone  family  with a partner  group For how long? \_\_\_\_\_

What stress-reducing activities do you do regularly? \_\_\_\_\_

Do you have any other problems you would like to discuss with the doctor? \_\_\_\_\_

**For women:**

Date of last PAP: \_\_\_\_\_ Date/duration of last menstrual period: \_\_\_\_\_

No. of children: \_\_\_\_\_ Ages: \_\_\_\_\_ No. of pregnancies: \_\_\_\_\_

Deliveries: \_\_\_\_\_ Complications: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Abortions: \_\_\_\_\_ Complications: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am ultimately responsible for any expenses incurred at Peninsula Naturopathic Clinic, P.S. I authorize the doctor to examine and treat my condition(s), which may include diagnostic tests deemed necessary for my care, medication and therapy.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date