

Dr Lauren Deville, NMD
Nature Cure Family Health

Patient Information

Today's date _____
Name _____ Age _____ Date of Birth _____
Address _____ Zip: _____
Phone (H) _____ (C) _____ (W) _____
Is it okay to leave a message? (H) Y N (C) Y N (W) Y N
Email _____ *(This will be used for us to communicate with you. We will also send you ONE welcome email for our newsletter, and you can opt-in for free monthly newsletters after that if you choose.)*
Occupation _____
Marital Status: M S W Spouse/Partner's Name: _____
Partner's or Parent's (if minor) workplace: _____ Phone _____
Referred by _____
Emergency Contact _____ Phone _____
How did you hear about us? ___ Facebook ___ website (drlaurendeville.com) ___ referral ___ Other (where?) _____
Insurance: _____

Chief Concerns

1. _____
2. _____
3. _____

When did this problem begin and what if anything caused the onset? _____

Have you been given a diagnosis for this problem: if so, what? _____

What kinds of treatment have you tried? _____

How committed are you to making necessary lifestyle adjustments in order to address this issue (on a scale of 1-10, 10 being very committed)? _____

What are you hoping to achieve from seeing me as a result of today's visit?

What do you hope to achieve from naturopathic medical treatment going forward? _____

List your Physicians and other caregivers and their specialties:

1. _____
2. _____
3. _____
4. _____

Past Medical History:

Major Illnesses, Operations and Injuries (list dates):

1. _____
2. _____
3. _____
4. _____

List current prescription medications:

	Drug Name	Dosage	Taking since...
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

List all vitamins, minerals, herbs and other natural supplements you are currently taking:

	Supplement Name and Dose	Brand	Purchased where?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Allergies:

Drugs: _____ Contact Allergies: _____

Inhalants: _____

Food Allergies or Sensitivities:

	Foods	Reactions
1.	_____	_____
2.	_____	_____
3.	_____	_____

Lifestyle:

Exercise:

	Description of Exercise	Duration	Times/week
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Diet: (Please list typical daily diet)

Breakfast	Lunch	Dinner	Snacks

Food Groups (check amounts typically consumed):

Foods	None	Low	Moderate	Excessive
Fruits				
Vegetables				
Chicken				
Fish				
Beef				
Pork				
Dairy				
Sugar				
Bread				
Pasta				
Coffee				

What do you use when you use a sweetener?

___ Sugar ___ Agave Syrup ___ Honey ___ Stevia ___ Sucanat ___ Equal ___ Sweet n
Low ___ Splenda

How many hours a week do you work? _____

What do you do to relax?

1. _____

2. _____
3. _____
4. _____

Height _____ Do you smoke? Yes No
 Weight _____ If so, how many cigarettes per day? _____
 Ideal Weight _____ Drink alcohol? Yes No
 Blood Type _____ Type _____ Frequency _____
 Any recreational drug use? Yes No If so, what kind? _____

Biggest source of stress?

1. _____
2. _____
3. _____

Any pets? ___ cat(s) ___ dog(s) ___ indoor ___ outdoor

Do you have any children? (if so, please provide names and ages)

Name	Age	Name	Age

Family History:

Relation	Current Age	Age at Death	Illnesses
Mother			
Father			
Grandmother (P)			
Grandfather (P)			
Grandmother (M)			
Grandfather (M)			
Siblings			

Relation	Current Age	Age at Death	Illnesses

Additional Family History (check all that apply)

Thyroid disease Cancer Heart Disease
 Allergies Diabetes Stroke

Do you have reactions to any of the following, and if so, how severe?

Reaction to:	None	Mild	Moderate	Very severe	Not sure
Cigarette smoke					
perfumes					
chlorine bleach					
car exhaust					
molds/mildews					
dust					
formaldehyde					

Water: what type of water do you drink?

Tap Bottled Distilled Reverse Osmosis Other: _____

Do you buy organic fruits and vegetables?

Never A few things when I can Most of what I buy

Yes	No	Unsure	Have you ever...
			Lived on a farm where chemical spraying had occurred?
			Lived or worked in new construction w/new materials?
			Lived or worked in a severely moldy environment?
			Lived or worked in a place suspected to be toxic?

Review of Symptoms (please check off any symptoms you are currently having)

HEAD

- Migraine headaches
- Sinus headaches
- Tension headaches
- Suffered a head injury?
- TMJ
- Other: _____

MUSCULOSKELETAL

- Muscle pain
- Muscle weakness
- Joint pain
- Shoulder problems
- Knee problems
- Neck problems
- Other: _____

EYES

- Glaucoma
- Cataracts
- Burning eyes
- Light sensitivity
- Eyestrain

EARS

- Loss of hearing
- Ringing
- Recurrent infections
- Dizziness
- Itching

NOSE

- Chronic congestion
- Sinus problems
- Nosebleeds
- Sinus infections
- Allergies

HEART

- Chest pain
- Palpitations
- Varicose veins
- High blood pressure
- Shortness of breath

LUNGS

- Cough
- Asthma
- Wheezing

BREAST

- Lumps
- Tenderness
- Nipple discharge
- Breast cysts
- Abnl mammograms

THROAT AND MOUTH

- Hoarseness
- Post-Nasal Drip
- Recurrent sore throats
- Cold sores
- Frequently coated tongue
- Oral ulcers inside mouth or under tongue

GASTROINTESTINAL

- Upset stomach
- Burning in stomach
- Pain in abdomen
- Belching
- Reflux
- Nausea
- Indigestion
- Gas
- Bloating
- Hemorrhoids
- Constipation
- Diarrhea
- Itchy anus
- Black, tarry stools
- Other: _____

GENITO-URINARY

- Frequent urination
- Difficult urination
- Genital Itching or burning

MALE ONLY

- Loss of normal erections
- Prostate problems

SKIN

- Acne
- Dry skin
- Eczema
- Hives
- Rashes

ENDOCRINE

- Weight gain
- Weight loss
- Excess thirst
- Fatigue
- Excess urination

- Cold extremities
- Excessive hair loss
- Change in hair texture

GENERAL

- Depression

- Anxiety
- Insomnia

- Poor memory
- Poor concentration

WOMEN ONLY:

Age of First Period: _____ Age of Menopause: _____ Date of Last Pap: ___/___/___

Period: Days Between Cycles: _____ Circle: Regular Irregular Days you bleed _____

Flow: Light Moderate Heavy Clotting? Yes No

Color of blood: Bright red Medium red Brown

Do you have spotting? Yes No

If so, when?

Before period - # of days? _____

Mid-cycle - # of days? _____

After period - # of days? _____

Cramps:

Mild Moderate Severe Progressively worsening over the years

PMS:

Never Sometimes Each time Severe Don't notice

If applicable, how many days? _____

Headaches with menses? Yes No

If so, when and what type? Check all that apply.

Before During After Mid-cycle

Migraine Tension Other

Breast tenderness? Yes No

Fatigue with menses? Yes No

Hysterectomy (if applicable):

Have you had a hysterectomy? Yes No

If so, when? _____

To what extent? Partial (ovaries left) Full

Reason for hysterectomy? Heavy bleeding Fibroids

Uterine prolapse Endometriosis Other: _____

Urinary incontinence:

Urine leakage while laughing or sneezing? Never Occasionally Often

Urine leakage when bladder is too full? Never Occasionally Often

Urine leakage when walking, running, jumping? Never Occasionally Often

Check off the symptoms you are experiencing:

Anxiety Depression Irritability Feeling not yourself

- Weepiness Insomnia Achy joints Foggy thinking
- Poor memory Poor word recall Weight gain
- Breast tenderness Heart palpitations Unusual skin sensations
- Headaches Water retention Dizziness

Hot flashes:

Frequency (times per year, month, week, or day) _____

Intensity: none mild medium intense extreme

Night sweats:

Frequency (times per year, month, week, or day) _____

Intensity: none mild medium intense extreme

Have you ever taken hormones before? Please list below along with doses and effects:

Have you tried anything natural to help with hormones? (i.e. herbs, vitamins, homeopathy, etc). Please list below along with doses and effects:

FEMALE SEXUAL HISTORY: (This section can be omitted all or in part if you have no concerns or are uncomfortable with any of the questions.)

Are you currently sexually active?

Yes No

Vaginal lubrication is: Good

Dry at times

Dry all the time

Ability to orgasm:

Good

Never experienced this in my life

Few and far between

More difficult than in earlier times

No longer able to

Libido is:

Good

Low for me

Non-existent

Up and down

My partner's libido is:

More than mine

Less than mine

About the same as mine

My libido:

Is not a big issue currently

Is lower, but I'm okay with it

Is a bit of a concern

Really bothers me and impacts my life negatively

If libido is low, I believe these could possibly be some of the reasons why:

(check as many as you think may apply)

Hormonal imbalance Pelvic pain Vaginal dryness Fatigue

Ever since my hysterectomy Past abuse issues Other health issues

Antidepressants or other meds I am currently taking Body image issues

Relationship struggles Help! I have not a clue Other: _____

Financial and Insurance Policy

Thank you for choosing us as your healthcare provider; we are committed to providing you with the best possible care. In order to avoid any misunderstandings please review our payment policy.

Unless payment arrangements have been made and approved in advance of scheduling your appointment, **payment is due in full at the time of service.** We accept cash, checks, or credit cards.

Visits are charged by length of time, at 15 minute increments.

1. Our fees are considered usual, customary and reasonable.
2. **Our office does not bill insurance.**
3. We use laboratories that will bill most insurance companies (excluding Medicare and Tricare) for you; this transaction is between you and the lab. **It is your responsibility to check with your insurance regarding their policy on coverage for labs.**
4. All services (e.g., lab and office visits) provided to Medicare patients by a naturopathic physician are not covered by Medicare.

Doctor's appointments which are missed or not cancelled within 24 hours will be assessed a \$25 fee. Simply not coming for an appointment or canceling on very short notice does not allow us to offer the appointment to someone else. Excessive no shows may result in discharge from the practice.

By signing below, I acknowledge I have read and understand the policy.

Patient Signature

Date