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					

Dental work: Have you had any of the following?
__ Root canals (How many and when?) _____
__ Metal amalgams (How many and when?) _____

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

ENDOCRINE
__ Weight gain
__ Cold extremities

__ Dry skin
__ Eczema
__ Hives
__ Rashes

__ Weight loss
__ Excess thirst
__ Fatigue
__ Excess urination

__ 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 $35 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