NEW PATIENT PROFILE

Please complete these pages as accurately and as completely as possible. If you need help, please ask. If possible, *please use a **blue ink pen** to make your form easier to read.*

Name:				**Date: / /**
First		Last		**Gender: M F**
Date of Birth: / /	Age:	Height	Weight:	Referred by:
Status **S M D W**idowed Children #:				
Home street address:				
City, State, Zip code				
Mailing Address (if preferred):				
City, State, Zip code:				

Home Phone:	Ok to leave a message?	Yes	No
Work Phone:	Ok to leave a message?	Yes	No
Mobile Phone:	Ok to leave a message?	Yes	No
Email:	Ok to leave a message?	Yes	No
Occupation:	Employer:		
Emergency Contact:	Phone:		

HEALTH INFORMATION (confidential)

Present Health Concerns: *Please list your most important health concerns. If possible, please list them in order of importance to you. For example, #1 is most important, and #5 is least important.*

1)
2)
3)
4)
5)

YOUR MAJOR GOALS FOR THE FIRST VISIT: Please *tell me what you would like to accomplish on the first visit.*

1)
2)
3)
4)

YOUR QUESTIONS: *What questions do you have for today's visit?*

_____

_____

ALLERGIES: Please *list all **food, environmental,** and/or **drug** allergies:*

_____

_____

Name:

Current **prescription medications** (eg., Prozac, atenolol, etc.) **non-prescription medications** (eg., aspirin, Tylenol, ibuprofen) and/or **health supplements** (eg.,vitamins, minerals, herbs): Please list the medications and/or supplements that you are currently taking with dosages:

Name of medication or supplement (drugs, vitamins, herbs, minerals)	**Dose** (in milligrams or grams or # capsules, tablets)	**Frequency**: Times per day/week/month	**Duration**: Been taking for how long?

MOST RECENT VISIT TO A DOCTOR: When was the last time you consulted a doctor, and for what reason? _____

Date of last complete physical exam: _____

Date of most recent lab/blood tests: _____

WOMEN–date of last PAP smear: / / Results: _____ **Currently pregnant?** Yes or Unsure

Medical procedures, hospitalizations, major injuries, and serious illnesses: Please list previous medical procedures, surgeries, hospitalizations, and serious illnesses.

Approximate date / year	**Surgery / hospitalization / procedure / injuries**

DIET: Do you follow any particular diet regimens or restrictions?

_____

_____

EXERCISE: Do you exercise regularly? If yes – what do you do? If no, what keeps you from exercising?

_____

_____

HABITS & LIFESTYLE: Please circle or list which of the following you use:

tobacco / cigarettes **alcohol** **prescriptions drugs** **black tea** **cola/ soda**

aspirin/Tylenol/analgesics **antacids** **recreational drugs** **coffee**

Other: _____

_____

REVIEW OF SYSTEMS: *I have designed the following form so that it will be easy for you to complete. Simply check the appropriate box for each attribute so that we can further discuss the specific areas of concern that you have—if you have additional comments or want to provide additional information, please make a note and we can discuss your concerns during the visit. Please provide additional information where you mark the answer "Yes-^." Your completing this form will enable us to work more efficiently during our time together and will allow a means by which to reassess your status on future visits.*

GENERAL HEALTH	***Very rare-None***	***Occasional-Mild***	***Intermittent-Moderate***	***Frequent-Severe***
Fatigue, lack of energy, lack of stamina	☐ 0	☐ 1	☐ 2	☐ 3
Need to decrease or alter activities of daily living due to fatigue, pain, or illness	☐ 0	☐ 1	☐ 2	☐ 3
Insomnia, lack of sleep	☐ 0	☐ 1	☐ 2	☐ 3
Excessive tiredness and increased need for sleep	☐ 0	☐ 1	☐ 2	☐ 3
Tired and/or not hungry after waking	☐ 0	☐ 1	☐ 2	☐ 3
Pain at night, night sweats	☐ 0	☐ 1	☐ 2	☐ 3
Enlarged lymph nodes	☐ 0	☐ 1	☐ 2	☐ 3
Frequent infections	☐ 0	☐ 1	☐ 2	☐ 3
Undesired weight loss	☐ 0	☐ 1	☐ 2	☐ 3
Undesired weight gain, difficulty losing weight	☐ 0	☐ 1	☐ 2	☐ 3
Cold hands or feet	☐ 0	☐ 1	☐ 2	☐ 3
Compulsive/binge eating, increased appetite	☐ 0	☐ 1	☐ 2	☐ 3
Decreased appetite	☐ 0	☐ 1	☐ 2	☐ 3
Hypoglycemia, low blood sugar	☐ 0	☐ 1	☐ 2	☐ 3
Allergies to food or environment	☐ 0	☐ 1	☐ 2	☐ 3
Sensitivity to fumes, chemicals, odors, exhaust	☐ 0	☐ 1	☐ 2	☐ 3
Have you been tested for iron disorders?	☐ NO	☐ YES		☐ ?
Past diagnosis of serious illness or chronic health condition such a systemic disease, cancer, HIV, mental condition, heart disease, infection, kidney problems, or other condition	☐ NO	☐ YES (please list)		
MUSCLES & JOINTS	***Very rare-None***	***Occasional-Mild***	***Intermittent-Moderate***	***Frequent-Severe***
Pain, swelling, or limited motion in joint(s)	☐ 0	☐ 1	☐ 2	☐ 3
Pain, swelling, or weakness in muscle(s)	☐ 0	☐ 1	☐ 2	☐ 3
Cramps in muscles, grind teeth at night?	☐ 0	☐ 1	☐ 2	☐ 3
Other problem, concerns, or questions in this area?	☐ NO	☐ YES (please list)		
HEAD & MIND	***Very rare-None***	***Occasional-Mild***	***Intermittent-Moderate***	***Frequent-Severe***
Headaches	☐ 0	☐ 1	☐ 2	☐ 3
Feeling of pressure inside head	☐ 0	☐ 1	☐ 2	☐ 3
Faintness, loss of consciousness	☐ 0	☐ 1	☐ 2	☐ 3
Dizziness	☐ 0	☐ 1	☐ 2	☐ 3
Seizures, epilepsy	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty thinking or processing information; confusion	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty with concentrating or maintaining attention	☐ 0	☐ 1	☐ 2	☐ 3
Poor memory	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty speaking or talking, slurred speech	☐ 0	☐ 1	☐ 2	☐ 3
Hyperactivity	☐ 0	☐ 1	☐ 2	☐ 3
Learning difficulties, dyslexia	☐ 0	☐ 1	☐ 2	☐ 3
Other problem, concern, or question in this area?	☐ NO	☐ YES (please list)		

EMOTIONS & SOCIAL HEALTH	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Depression, sadness	☐ 0	☐ 1	☐ 2	☐ 3
Anger, irritability, anxiety	☐ 0	☐ 1	☐ 2	☐ 3
Stressful situations	☐ 0	☐ 1	☐ 2	☐ 3
Apathy, lack of interest or concern	☐ 0	☐ 1	☐ 2	☐ 3
Use of alcohol, herbs, drugs, or medications to help manage emotions	☐ 0	☐ 1	☐ 2	☐ 3
Isolation, few friends, distant family	☐ 0	☐ 1	☐ 2	☐ 3
Problems with parents or family	☐ 0	☐ 1	☐ 2	☐ 3
Problems with employer(s) or coworker(s)	☐ 0	☐ 1	☐ 2	☐ 3
Sadness or recurrent problems from childhood or past events	☐ 0	☐ 1	☐ 2	☐ 3
Recent or current thoughts of suicide?	☐ NO	☐ YES (explain)		
Diagnosed mental condition such as bipolar, schizophrenia, or other condition	☐ NO	☐ YES (explain)		
Other problem, concern, or question in this area?	☐ NO	☐ YES (explain)		

EYES	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Watery, red, or itchy eyes	☐ 0	☐ 1	☐ 2	☐ 3
Dark circles under eyes	☐ 0	☐ 1	☐ 2	☐ 3
Decrease or loss of vision; cataracts, or glaucoma	☐ 0	☐ 1	☐ 2	☐ 3
Poor night vision, night blindness	☐ 0	☐ 1	☐ 2	☐ 3
Pain in eye(s)	☐ 0	☐ 1	☐ 2	☐ 3
Pain near or behind eye(s)	☐ 0	☐ 1	☐ 2	☐ 3
Other problem, concern, or question in this area?	☐ NO	☐ YES (explain)		

EARS	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Earaches, pain in ear(s)	☐ 0	☐ 1	☐ 2	☐ 3
Ringing in ear(s)	☐ 0	☐ 1	☐ 2	☐ 3
Ear infections	☐ 0	☐ 1	☐ 2	☐ 3
Decrease or loss of hearing	☐ 0	☐ 1	☐ 2	☐ 3
Other problem, concern, or question in this area?	☐ NO	☐ YES (explain)		

MOUTH, NOSE, & THROAT	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Swollen or tender tongue or gums	☐ 0	☐ 1	☐ 2	☐ 3
Decreased sense of taste or smell	☐ 0	☐ 1	☐ 2	☐ 3
Stuffy nose, nasal congestion	☐ 0	☐ 1	☐ 2	☐ 3
Sinus infections, sinus pain	☐ 0	☐ 1	☐ 2	☐ 3
Nasal polyps	☐ 0	☐ 1	☐ 2	☐ 3
Ulcers or sores in mouth or lips, oral herpes	☐ 0	☐ 1	☐ 2	☐ 3
Allergies/ sneezing/ runny nose	☐ 0	☐ 1	☐ 2	☐ 3
Excessive mucus formation	☐ 0	☐ 1	☐ 2	☐ 3
Drainage to back of throat	☐ 0	☐ 1	☐ 2	☐ 3
Sore throat	☐ 0	☐ 1	☐ 2	☐ 3
Cough or wheeze	☐ 0	☐ 1	☐ 2	☐ 3
Change in voice	☐ 0	☐ 1	☐ 2	☐ 3
Hoarseness, loss of voice	☐ 0	☐ 1	☐ 2	☐ 3
Other problem, concern, or question in this area?	☐ NO	☐ YES (explain)		

MOUTH, NOSE, & THROAT	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Pain in left arm and/or left side of neck or face	☐ 0	☐ 1	☐ 2	☐ 3
Shortness of breath, difficulty breathing	☐ 0	☐ 1	☐ 2	☐ 3
Irregular heartbeat	☐ 0	☐ 1	☐ 2	☐ 3
Rapid or pounding heartbeat	☐ 0	☐ 1	☐ 2	☐ 3
Chest congestion, bronchitis	☐ 0	☐ 1	☐ 2	☐ 3
Asthma	☐ 0	☐ 1	☐ 2	☐ 3
Medications for lungs or heart	☐ 0	☐ 1	☐ 2	☐ 3
Current or past cigarette smoking or tobacco use	☐ 0	☐ 1	☐ 2	☐ 3
Pain in chest	☐ NO	☐ YES (explain)		
High blood pressure, high cholesterol, or high triglycerldes?	☐ NO	☐ YES (explain)		
Other problem, concern, or question in this area?	☐ NO	☐ YES (explain)		

SKIN, HAIR, & NAILS	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Acne	☐ 0	☐ 1	☐ 2	☐ 3
Eczema	☐ 0	☐ 1	☐ 2	☐ 3
Psoriasis	☐ 0	☐ 1	☐ 2	☐ 3
Dry skin	☐ 0	☐ 1	☐ 2	☐ 3
Oily skin	☐ 0	☐ 1	☐ 2	☐ 3
Flushing, hot flashes	☐ 0	☐ 1	☐ 2	☐ 3
Itchy skin (with or without redness) or hives	☐ 0	☐ 1	☐ 2	☐ 3
Decrease in body or facial hair	☐ 0	☐ 1	☐ 2	☐ 3
Decrease in head hair (not male pattern baldness)	☐ 0	☐ 1	☐ 2	☐ 3
Increase in body or facial hair	☐ 0	☐ 1	☐ 2	☐ 3
Excessive sweating	☐ 0	☐ 1	☐ 2	☐ 3
Insufficient sweating when hot or active	☐ 0	☐ 1	☐ 2	☐ 3
Area(s) of numbness	☐ 0	☐ 1	☐ 2	☐ 3
Area(s) of tingling	☐ 0	☐ 1	☐ 2	☐ 3
Area(s) of pain	☐ 0	☐ 1	☐ 2	☐ 3
Weak or ridged fingernails	☐ NO	☐ YES (explain)		
Change in skin color or pigmentation, vitiligo	☐ NO	☐ YES (explain)		
Small rough bumps on back of upper arms	☐ NO	☐ YES (explain)		
Other problem, concerns, or questions in this area?	☐ NO	☐ YES (explain)		

STOMACH & DIGESTIVE TRACT	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Heartburn	☐ 0	☐ 1	☐ 2	☐ 3
Poor digestion	☐ 0	☐ 1	☐ 2	☐ 3
Nausea	☐ 0	☐ 1	☐ 2	☐ 3
Vomiting	☐ 0	☐ 1	☐ 2	☐ 3
Diarrhea	☐ 0	☐ 1	☐ 2	☐ 3
Constipation	☐ 0	☐ 1	☐ 2	☐ 3
Belching, intestinal bloating, gas or flatulence	☐ 0	☐ 1	☐ 2	☐ 3
Pain in stomach, intestines, colon	☐ 0	☐ 1	☐ 2	☐ 3
Rectal itching, pain, or bleeding	☐ 0	☐ 1	☐ 2	☐ 3
Hemorrhoids	☐ 0	☐ 1	☐ 2	☐ 3
Loss of bowel control, incontinence	☐ 0	☐ 1	☐ 2	☐ 3
Other problem, concern, or question in this area?	☐ NO	☐ YES (explain)		

Notes: _____

KIDNEYS & GENITALS	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Kidney stones	☐ 0	☐ 1	☐ 2	☐ 3
Other kidney problems	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty controlling urination, incontinence	☐ 0	☐ 1	☐ 2	☐ 3
Bladder problems (other than infections)	☐ 0	☐ 1	☐ 2	☐ 3
Frequent urination	☐ 0	☐ 1	☐ 2	☐ 3
Pain or burning with urination	☐ 0	☐ 1	☐ 2	☐ 3
Discharge or blood in urine	☐ 0	☐ 1	☐ 2	☐ 3
Urinary tract (kidney, bladder, urethra) infection(s)	☐ 0	☐ 1	☐ 2	☐ 3
Sexually transmitted disease(s)	☐ 0	☐ 1	☐ 2	☐ 3
Genital herpes	☐ 0	☐ 1	☐ 2	☐ 3
Low sex drive, low libido	☐ 0	☐ 1	☐ 2	☐ 3
Have you been tested for HIV?	☐ Negative	☐ Positive	☐ Not tested	
Other problem, concern, or question in this area?	☐ NO	☐ YES (explain)		

For WOMEN only — HORMONAL STATUS & SEXUAL FUNCTION	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Irregular menses	☐ 0	☐ 1	☐ 2	☐ 3
Painful menses	☐ 0	☐ 1	☐ 2	☐ 3
Pain between menses	☐ 0	☐ 1	☐ 2	☐ 3
Painful, swollen, or fibrocystic breasts	☐ 0	☐ 1	☐ 2	☐ 3
Water retention	☐ 0	☐ 1	☐ 2	☐ 3
Premenstrual syndrome	☐ 0	☐ 1	☐ 2	☐ 3
Excessive bleeding	☐ 0	☐ 1	☐ 2	☐ 3
Abnormal uterine bleeding	☐ NO	☐ YES (explain)		
Missed menses	☐ 0	☐ 1	☐ 2	☐ 3
Vaginal dryness, irritation, painful intercourse	☐ 0	☐ 1	☐ 2	☐ 3
Yeast infections	☐ 0	☐ 1	☐ 2	☐ 3
Uterine fibroids	☐ NO	☐ YES (explain)		
Menopausal symptoms or concerns	☐ NO	☐ YES (explain)		
Infertility	☐ NO	☐ YES (explain)		
Annual Pap smear, breast examination, and health checkup?	☐ NO	☐ YES (explain)		
Family history of breast, uterine, or ovarian cancer	☐ NO	☐ YES (explain)		
Other problem, injury, concern in this area?	☐ NO	☐ YES (explain)		

FOR MEN ONLY— HORMONAL STATUS & SEXUAL FUNCTION	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Pain or difficulty obtaining or maintaining erection	☐ 0	☐ 1	☐ 2	☐ 3
Pain or difficulty with ejaculation	☐ 0	☐ 1	☐ 2	☐ 3
Pain or mass in testicles	☐ 0	☐ 1	☐ 2	☐ 3
Slow stream of urine or frequent urination	☐ 0	☐ 1	☐ 2	☐ 3
Undescended testis, testis in abdomen or pelvis	☐ NO	☐ YES (explain)		
Men over 50: annual PSA test and prostate exam?	☐ NO	☐ YES (explain)		
Family history of prostate cancer	☐ NO	☐ YES (explain)		
Other problem, injury, concern in this area?	☐ NO	☐ YES (explain)		

Additional notes or comments:

_____

_____