Natural Healthcare Center
Integrated Health & Wellness Programs

Patient Questionnaire (Please print clearly)

For office use only: New ____ Reactivated ____ PI ____

Section 1:

Name (First)_____ (Last) _____

Address _____**City**_____ **State** _____ **Zip** _____

Social Security # _____ **Gender** ☐ Male ☐ Female **Date of Birth**: _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Spouse Name** _____

Language preference: ☐ English ☐Spanish ☐Other:_____ **Ethnicity** (Italian, Polish, etc.):_____

Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Middle-Eastern ☐ Pacific Islander ☐ Native American

Home Phone# _____ **Cell Phone#** _____

Email Address: _____

Would you like to subscribe to Dr. Proodian's blog with helpful articles on health and wellness? ☐ Yes ☐ No

Parent/Guardian Name:_____ **Relation to patient:** _____

Parent/Guardian Phone: _____ **Parent/Guardian email address:** _____

Emergency Contact Name:_____ **Relation:**_____ **Phone:**_____

How were you referred to our office? _____

Your Occupation _____Employer_____

Address _____City_____ State _____ Zip _____

Person who holds primary health insurance, if other than yourself: Name _____

Date of Birth _____ Relation: _____Employer: _____ Insurance Carrier: _____

Person who holds secondary health insurance, if other than yourself: Name _____

Date of Birth _____ Relation: _____Employer: _____ Insurance Carrier: _____

Do you have an HSA/FSA (Health Savings or Flexible Spending Account)? ☐ Yes ☐ No If so, who administers? _____

Do you have a pacemaker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Your Height: _____ft. _____inches Weight: _____lbs.

Do you smoke? ☐ Yes ☐ No If no, have you quit within the past 24 months (2 years)? ☐ Yes ☐ No

Have you been diagnosed with the following? ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Hypertension

If you are 65 years of age or older, have you received a Pneumonia Vaccination? ☐ Yes ☐ No If yes, when? _____

If you are between the ages of 50-75, have you received appropriate screening for Colorectal Cancer, such as colonoscopy, fecal blood testing or sigmoidoscopy? ☐ Yes ☐ No If yes, when? _____

Section 2:

Medications

Date Started	Medication	Dosage

Allergies to Medication

Medicine	Reaction
_____	_____
_____	_____

Family Medical History:

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Depression ☐ Seizure

☐ Hepatitis ☐ Alcoholism ☐ High Blood Pressure ☐ Thyroid Disease ☐ Other: _____

Section 3:

Have you had or currently have any of the following conditions?

Musculoskeletal/Pain

☐ Osteoporosis/Osteopenia
☐ Scoliosis
☐ Muscle Pain
☐ Arm Numb/Tingling
☐ Leg Numb/Tingling
☐ Neck Pain
☐ Middle Back Pain
☐ Low Back Pain
☐ Shoulder Pain
☐ Elbow Pain
☐ Hand/Wrist Pain
☐ Hip Pain
☐ Knee Pain
☐ Ankle/Foot Pain
☐ Joint Pain – where? _____
☐ Other _____

Gastrointestinal

☐ Irritable Bowel Syndrome
☐ Inflammatory Bowel Disease
☐ Crohn's
☐ Ulcerative Colitis
☐ Gastritis or Peptic Ulcer Disease
☐ GERD (reflux)
☐ Celiac Disease
☐ Other _____

Cardiovascular

☐ Heart Attack
☐ Stroke
☐ Elevated Cholesterol
☐ Hypertension (high blood pressure)
☐ Other _____

Inflammatory/Autoimmune

☐ Chronic Fatigue Syndrome
☐ Autoimmune Disease
☐ Rheumatoid Arthritis
☐ Lupus SLE
☐ Immune Deficiency Disease
☐ Poor Immune Function (Frequent Infections)
☐ Food Allergies
☐ Environmental Allergies
☐ Multiple Chemical Sensitivities
☐ Latex Allergy
☐ Other _____

Metabolic/Endocrine

☐ Type 1 Diabetes
☐ Type 2 Diabetes
☐ Hypoglycemia
☐ Metabolic Syndrome
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Endocrine Problems
☐ Infertility
☐ Weight Gain
☐ Weight Loss
☐ Frequent Weight Fluctuations
☐ Bulimia
☐ Anorexia
☐ Eating Disorder (non-specific)
☐ Other _____

Cancer

☐ Type _____
☐ Type _____
☐ Type _____

Genital and Urinary Systems

☐ Kidney Stones
☐ Gout
☐ Frequent Yeast Infections
☐ Erectile or Sexual Dysfunction

Respiratory Diseases

☐ Asthma
☐ Chronic Sinusitis
☐ Bronchitis
☐ Emphysema
☐ Pneumonia
☐ Tuberculosis
☐ Sleep Apnea
☐ Other _____

Skin Diseases

☐ Eczema
☐ Psoriasis
☐ Acne
☐ Melanoma
☐ Skin Cancer: Type _____

Neurologic/Mood

☐ Depression
☐ Anxiety
☐ Bipolar Disorder
☐ Headaches
☐ Migraines
☐ ADD/ADHD
☐ Memory Problems
☐ Parkinson's disease
☐ Multiple Sclerosis
☐ Other Neurological Problems
_____

Preventative Tests and Date of Last Test

☐ Full Physical Exam _____
☐ Bone Density _____
☐ Colonoscopy _____
☐ Cardiac Stress Test _____
☐ EBT Heart Scan _____
☐ EKG _____
☐ Hemoccult Test-stool test for blood
_____
☐ MRI _____
☐ CT Scan _____
☐ Upper Endoscopy _____
☐ Upper GI Series _____
☐ Ultrasound _____

Surgeries and Date

☐ Appendectomy _____
☐ Hysterectomy _____
☐ Gall Bladder _____
☐ Hernia _____
☐ Tonsillectomy _____
☐ Dental Surgery _____
☐ Joint Replacement Knee/Hip
_____
☐ Heart Surgery
Type _____
Date _____
☐ Other: Type _____
Date _____

Hospitalization (last 5 years)

Reason _____
Date _____
Reason _____
Date _____
Reason _____
Date _____

Section 4:

Neurology and Podiatry Survey

Your answers to the following questions will help us develop a more complete picture of your overall health.

Please indicate which conditions apply to you:

Neurology

- ☐ Dizziness
- ☐ Spontaneous movements or tics
- ☐ Tremors or shakes
- ☐ Persistent muscular spasm
- ☐ Poor balance
- ☐ Unexplained falls lately
- ☐ Trouble maintaining your attention
- ☐ Frequent headaches
- ☐ Traumatic head injury
- ☐ Concussion
- ☐ Double vision
- ☐ Problems with memory
- ☐ Problems with bladder control
- ☐ Difficulties achieving or maintaining sexual arousal
- ☐ Obsess over rituals or habits
- ☐ Learning or behavioral disorder
- ☐ Bedwetting
- ☐ Seizure disorder

Podiatry

- ☐ Bunions
- ☐ Hammer Toes
- ☐ Flat Feet
- ☐ Foot Pain
- ☐ Heel Pain
- ☐ Ankle Pain
- ☐ Ankle Instability
- ☐ Ingrown Nail
- ☐ Achilles Tendonitis or Pain
- ☐ Arthritis in your Feet
- ☐ Previous Foot Surgery
- ☐ Recurring Ankle Sprains
- ☐ Plantar Fasciitis
- ☐ Scoliosis
- ☐ Sacroiliac Pain

* * * * * * * * * * * * * * * * * *

The Patient, by signing below, affirm that they have read all pages of this document, understand its contents, have had all of their questions answered if any, and attest to the accuracy of the information provided therein.

Pregnancy Verification (female patients only). Please initial: _____ I am pregnant _____ I am not pregnant

Consent to Treatment of Minor Child (for parents/guardians of children under 18). Please initial:

I hereby authorize Natural Healthcare Center, its employees, agents, and/or contractors and whomever he/she may designate as assistant to administer treatment as deemed necessary to my child or guardian child. Initials: _____

Print name: (☐ self ☐ parent or legal guardian): _____

Signature: (☐ self ☐ parent or legal guardian): _____

Date: _____