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: _____

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

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

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

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 Height: _____ft. _____inches Weight: _____lbs.

Section 2:

Medications

Date Started	Medication	Dosage

Allergies to Medication

Medicine	Reaction

Family Medical History:

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

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 _____

Section 4:

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: _____