

# New Patient Questionnaire

Connecticut Integrated Naturopathics

## Personal Information

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Today's Date \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email address \_\_\_\_\_ Phone (home) \_\_\_\_\_  
Phone (cell) \_\_\_\_\_ Phone (work) \_\_\_\_\_

Emergency Contact:  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship to patient \_\_\_\_\_

In order to ensure your privacy, please indicate where we may leave messages for you by checking the appropriate line: Never \_\_\_ Home answering machine \_\_\_ Work \_\_\_ Cell phone \_\_\_  
With family members (please specify, if necessary) \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Please list your primary health concerns in order of their importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Doctor(s) currently seen: (Please continue on a separate page, if needed)

|                            |                                  |
|----------------------------|----------------------------------|
| Name _____                 | Practice Name _____              |
| Address _____              | City _____ State _____ Zip _____ |
| Office phone (_____) _____ | Fax (_____) _____                |

|                            |                                  |
|----------------------------|----------------------------------|
| Name _____                 | Practice Name _____              |
| Address _____              | City _____ State _____ Zip _____ |
| Office phone (_____) _____ | Fax (_____) _____                |

|                            |                                  |
|----------------------------|----------------------------------|
| Name _____                 | Practice Name _____              |
| Address _____              | City _____ State _____ Zip _____ |
| Office phone (_____) _____ | Fax (_____) _____                |

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## Health History

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Please list all hospitalizations for any reason (include dates): \_\_\_\_\_

Accidents \_\_\_\_\_

Surgeries \_\_\_\_\_

Major illnesses, past or present \_\_\_\_\_

History of sexually transmitted diseases \_\_\_\_\_

Are you aware of having any allergies to any of the following? If so, describe your reaction to each:

Drugs \_\_\_\_\_

Foods \_\_\_\_\_

Chemicals/Perfumes \_\_\_\_\_

Animals \_\_\_\_\_

Environmental allergens: pollen, mold, dust, etc. \_\_\_\_\_

Are your immunizations current? \_\_\_\_\_

Please list childhood diseases you have had (mumps, rubella, chickenpox, measles, whooping cough, eczema, diphtheria, roseola, rheumatic fever, scarlet fever, polio, other): \_\_\_\_\_

Please list all medications and supplements you are currently taking. Include dosages if known: (\*Please bring them to your first visit\*)

1) Prescription \_\_\_\_\_

2) Over-the-counter \_\_\_\_\_

3) Supplements/Herbals \_\_\_\_\_

## Family History

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Please indicate whether anyone in your immediate family has or had any of the following conditions (specify who is/was affected):

Allergies \_\_\_\_\_

Arthritis \_\_\_\_\_

Bipolar disorder \_\_\_\_\_

Depression \_\_\_\_\_

Epilepsy \_\_\_\_\_

High blood pressure \_\_\_\_\_

Hypothyroid \_\_\_\_\_

Kidney disease \_\_\_\_\_

Osteoporosis \_\_\_\_\_

Stroke \_\_\_\_\_

Weight issues \_\_\_\_\_

Alzheimer's disease \_\_\_\_\_

Asthma \_\_\_\_\_

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Disease \_\_\_\_\_

High cholesterol \_\_\_\_\_

Hyperthyroid \_\_\_\_\_

Multiple sclerosis \_\_\_\_\_

Parkinson's disease \_\_\_\_\_

Alcoholism/substance abuse \_\_\_\_\_

Other \_\_\_\_\_

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## Connecticut Integrated Naturopathics

### Review of Systems

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Please indicate whether you have ever had the following conditions, now or in the past:

**Mental/Emotional**                      now    past  
 Anxiety                                      \_\_\_\_\_  
 Depression                                    \_\_\_\_\_  
 Poor concentration                        \_\_\_\_\_  
 Memory problems                         \_\_\_\_\_

**Endocrine**                                      now    past  
 Weight gain/loss                         \_\_\_\_\_  
 Skin, hair, nail problems                \_\_\_\_\_  
 Changes in thirst/appetite              \_\_\_\_\_  
 Temperature sensitivity \_\_\_\_\_ \_\_\_\_\_

**Head**    now    past  
 Headaches                                    \_\_\_\_\_  
 Jaw / facial pain or twitching         \_\_\_\_\_  
 Head injuries                                \_\_\_\_\_  
 Vertigo or dizziness                      \_\_\_\_\_

**Ears**    now    past  
 Decreased hearing                        \_\_\_\_\_  
 Ringing                                        \_\_\_\_\_

**Eyes**    now    past  
 Visual impairment                        \_\_\_\_\_  
 Dryness                                        \_\_\_\_\_  
 Excessive tearing                         \_\_\_\_\_  
 Cataracts / glaucoma                    \_\_\_\_\_

**Nose / Sinuses**                              now    past  
 Sinus pain or stuffiness                \_\_\_\_\_  
 Nosebleeds                                 \_\_\_\_\_  
 Loss of smell                                \_\_\_\_\_

**Mouth and Throat**                        now    past  
 Teeth grinding                              \_\_\_\_\_  
 Gum disease /bleeding / pain         \_\_\_\_\_  
 Dental cavities                             \_\_\_\_\_  
 Hoarseness                                 \_\_\_\_\_  
 Difficulty swallowing                    \_\_\_\_\_

**Immune**                                        now    past  
 Fatigue                                        \_\_\_\_\_  
 Swollen glands                             \_\_\_\_\_  
 Allergies                                     \_\_\_\_\_  
 Unexplained fever                        \_\_\_\_\_  
 Frequent colds or flu                    \_\_\_\_\_

**Respiratory**                                    now    past  
 Cough                                         \_\_\_\_\_  
 Cough up blood                            \_\_\_\_\_  
 Asthma                                        \_\_\_\_\_  
 Shortness of breath                      \_\_\_\_\_  
 When do you experience it? \_\_\_\_\_

**Neck**    now    past  
 Change in size of neck / lumps        \_\_\_\_\_  
 Pain or stiffness                         \_\_\_\_\_

**Skin**  
 List any concerns \_\_\_\_\_

**Neurological**                                now    past  
 Seizures                                      \_\_\_\_\_  
 Muscle weakness                         \_\_\_\_\_  
 Numbness / tingling                     \_\_\_\_\_  
 Tremors                                      \_\_\_\_\_

**Musculoskeletal**                        now    past  
 Joint pain / stiffness                    \_\_\_\_\_  
 Swollen joints                             \_\_\_\_\_  
 Muscle spasms / cramps                \_\_\_\_\_

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| <b>Cardiovascular</b> | now   | past  |
|-----------------------|-------|-------|
| Fainting              | _____ | _____ |
| Heart disease         | _____ | _____ |
| Chest pain, angina    | _____ | _____ |
| Heart murmur          | _____ | _____ |
| Palpitation           | _____ | _____ |
| Rapid / skipped beats | _____ | _____ |
| Swollen feet          | _____ | _____ |
| Low blood pressure    | _____ | _____ |
| High blood pressure   | _____ | _____ |

| <b>Urinary</b>              | now   | past  |
|-----------------------------|-------|-------|
| Pain / discomfort           | _____ | _____ |
| Incontinence                | _____ | _____ |
| Increased urinary frequency | _____ | _____ |
| Kidney stones               | _____ | _____ |

| <b>Female Reproductive</b> | now   | past  |
|----------------------------|-------|-------|
| Painful period             | _____ | _____ |
| Irregular bleeding         | _____ | _____ |
| PMS symptoms               | _____ | _____ |
| Please specify:            | _____ | _____ |
| Menopausal symptoms        | _____ | _____ |
| Please specify:            | _____ | _____ |
| Use of birth control       | _____ | _____ |
| Specify type:              | _____ | _____ |
| Sexual concerns            | _____ | _____ |
| Please specify:            | _____ | _____ |
| Breast lumps               | _____ | _____ |
| Breast tenderness          | _____ | _____ |
| Nipple discharge           | _____ | _____ |

| <b>Gastrointestinal</b>      | now   | past  |
|------------------------------|-------|-------|
| Nausea / vomiting            | _____ | _____ |
| Pain / discomfort in abdomen | _____ | _____ |
| Constipation                 | _____ | _____ |
| Diarrhea                     | _____ | _____ |
| Gallbladder disease          | _____ | _____ |
| Loss of appetite             | _____ | _____ |
| Heartburn / reflux           | _____ | _____ |
| Excessive belching / gas     | _____ | _____ |
| Hemorrhoids                  | _____ | _____ |
| Hernia                       | _____ | _____ |

| <b>Male Reproductive</b> | now   | past  |
|--------------------------|-------|-------|
| Prostate concerns        | _____ | _____ |
| Please specify:          | _____ | _____ |
| Sexual concerns          | _____ | _____ |
| Please specify:          | _____ | _____ |
| Condom use               | _____ | _____ |

| <b>Female Reproductive (cont.)</b>      |                |
|---|----------------|
| Age of first menstrual period           | _____          |
| Date of last menstrual period           | _____          |
| Length of cycle                         | _____          |
| Duration of bleeding                    | _____          |
| Do you perform self-breast exams? Y / N | _____          |
| Date of last PAP                        | ____/____/____ |
| Number of pregnancies                   | _____          |
| Number of live births                   | _____          |
| Number of miscarriages                  | _____          |
| Number of abortions                     | _____          |

I certify that the information I have provided is true to the best of my knowledge.

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Name (Please print)

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Signature

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Date