PENINSULA NATURAL HEALTH CENTER

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CONFIDENTIAL NEW PATIENT FORM

NAME (last, first, m.) _____ AGE _____ DATE OF BIRTH ___/___/___

☐ male ☐ female EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

( ) HOME/CELL PHONE-1 _____ ( ) ALTERNATE PHONE-2 _____ SOCIAL SECURITY NUMBER _____

EMAIL ADDRESS _____ REFERRED BY _____ DATE ___/___/___

INSURANCE COMPANY (primary) _____ POLICY NUMBER _____

INSURANCE COMPANY (secondary) _____ POLICY NUMBER _____

NAME OF INSURED _____ INSURED's SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EFFECTIVE DATE OF INSURANCE _____

EMERGENCY CONTACT NAME _____ ( ) HOME PHONE _____ RELATIONSHIP TO PATIENT _____

PLEASE CHECK THE APPROPRIATE BOX: ☐ single ☐ married ☐ partnered ☐ divorced ☐ widowed ☐ separated

Please list any current symptoms you may have in order of importance:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SURGERIES (year/type) _____

SERIOUS ILLNESS AND/OR ACCIDENTS (year/cause) _____

MEDICATIONS: (please list all supplements, prescriptions and non-prescription drugs)

NAME OF MEDICATION	TAKEN HOW OFTEN?	WHEN DID YOU START/STOP TAKING IT?

Other medications you have taken in the last 5 years: _____

HABITS:

	NEVER	RARELY	OCCASIONALLY	
Coffee:				Weekly/Daily Amount:
Black Tea:				Weekly/Daily Amount:
Tobacco:				Weekly/Daily Amount:
Alcohol:				Weekly/Daily Amount:
Laxatives:				Weekly/Daily Amount:
Aspirin:				Weekly/Daily Amount:
Drugs:				Weekly/Daily Amount:
Other:				Weekly/Daily Amount:

NAME/LOCATION/DATE OF LAST DOCTOR VISITED

OTHER PRACTITIONERS SEEN

DO YOU EAT A SPECIAL DIET?

WORK hours/week | SLEEP hours/week | GENERAL QUALITY OF SLEEP

EXERCISE hours/week | TYPE OF EXERCISE | Are you willing to change your living habits to improve your health?

/ / | PRACTITIONER

DATE OF LAST COMPLETE CHECKUP

PLEASE LIST chemicals, metals, dusts or fumes you are repeatedly exposed to, or which you were repeatedly exposed to in the past

(please include dates):

DO YOU REACT TO POLLENS? | TO FOODS? (what type?)

DO YOU USE A CONTRACEPTIVE? ☐ yes ☐ no IF YES, WHAT TYPE?

IF ANY FAMILY MEMBERS HAVE HAD THE FOLLOWING, PLEASE CHECK:

☐ allergies	☐ bleeding tendency	☐ diabetes	☐ hearing loss	☐ kidney disease
☐ alcoholism	☐ blindness	☐ epilepsy	☐ high blood pressure	☐ nervous/mental disorder
☐ asthma	☐ cancer	☐ heart disease	☐ hypoglycemia	☐ tuberculosis

OTHER (please describe)

LIVING SITUATION: ☐ alone ☐ family ☐ with a partner ☐ group FOR HOW LONG?

WHAT STRESS-REDUCING ACTIVITIES DO YOU DO REGULARLY?

DO YOU HAVE ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?

FOR WOMEN:

/ / DATE OF LAST PAP | / / DATE OF LAST PERIOD | DURATION | # OF CHILDREN | AGES

DELIVERIES | COMPLICATIONS | MISCARRIAGES

ABORTIONS | COMPLICATIONS

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am ultimately responsible for any expenses incurred at Peninsula Natural Health Center. I authorize the doctor to examine and treat my condition(s), which may include diagnostic tests deemed necessary for my care, medication and therapy.

PATIENT SIGNATURE | / / DATE