Connecticut Center for Natural Health

210 S. Main St. Suite 200, Middletown, CT phone: 860 347 8600 fax: 860 347 8434

New Patient Questionnaire

Date ____/_____/_____

PLEASE DO NOT MAIL QUESTIONNAIRE. BRING IT WITH YOU TO YOUR APPOINTMENT.

Last Name _____ First _____ Middle Initial _____ Age _____

Date of Birth ____/____/____ NickName _____ Gender_____ Pronoun Preferred_____

Address _____

City _____ State _____ Zip Code _____–_____

Home Phone _____ Cell Phone _____Work _____

Email _____

How did you learn about the Center?_____

Do you give us permission to share findings and converse with your primary doctor and other providers? ☐ Yes ☐ No

Primary Care Physician_____ Phone_____ Fax_____

Are you covered by medical insurance? Yes or No If yes, who? _____

Is this your **"primary**" insurance coverage? Yes or No

Your Insurance ID # _____ Group Name or # _____

Who's Name is the insurance in? (the subscriber) _____ ID# _____

Who will be responsible for payment of services? _____

Name of spouse, parent, relative, friend, or significant other _____

What health concern would you like to discuss in your initial visit?_____

Do you have other health concerns you would like to address at subsequent visits? List in order of importance.

1. _____ 3. _____

2. _____ 4. _____

What are your thoughts on these concerns? Do you have any ideas as to what might be the underlying cause of your symptoms?

_____

_____

_____

_____

When was the **last time you experienced optimal health?** _____

Current Height _____Current Weight _____

Please write the specific health results you would like to achieve in working with the doctor. _____

_____

_____

_____

_____

Have you ever been hospitalized? Yes or No If yes, please provide specifics where indicated below.

Condition Treated or Surgical Procedure Performed	Date	Hospital
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

Are you allergic to any foods, drugs or other substances? If yes, please list.

Food\Drug\Substance	Allergic Reaction(s)
_____	_____
_____	_____
_____	_____

Have you ever been treated by a Naturopath? _____

Have you ever had acupuncture? _____

Do you presently experience any of the following on a regular basis? (please circle)

Sadness, Crying Spells, Depression, Despair, Suicidal Thoughts, Fatigue, Tension, Easily Frustrated, Anxiety, Fear, Panic Attacks, Nightmares, Obsessive or Compulsive Behaviors, Inability to Communicate

Are you currently under the care of a mental health professional? Yes, No

Do you consume caffeine or other caffeinated drinks? If so, how many per day? _____

How many oz. of water do you consume per day? _____

Do you consume sugar? If so, how many treats or sugary drinks per week? _____

Do you have any cravings? If so, please list _____.

Date of last physical exam? _____ Date of last chest x-ray? _____ Blood work performed? Yes or No

When did you last receive medical care? ____/____/____ Where? _____

What condition(s) were you treated for? _____

Do you have **house pets?** Yes or No If yes list _____

Please review this list of conditions, **CHECK ONLY THOSE ITEMS YOU ARE EXPERIENCING PRESENTLY.**

	Rough, Dry or Scaly Skin		Unexplained Fever		Unexplained weight gain or loss
	Psoriasis or Eczema		Burst of Energy following exercise		Overweight
	Itching Skin		Difficulty concentrating		Chronic Fatigue
	Pimples		Difficulty Sleeping		Increased thirst
	Brittle Nails		Difficulty Relieving Stress		Night Sweats
	Burning Skin				Wounds slow to heal
	Boils or Canker Sores		Dizziness		Swelling of Neck
	Skin Rash		Pain in Ears		Neck stiffness
	Skin Color Changes		Ringing in Ears		
	Hair Color Changes		Excessive Ear wax		Neck Pain
			Frequent Ear infections		Goiter
	Numbness		Discharge from Ears		Unusual Growths of Hair
	Paralysis		Loss of hearing		
	Loss of memory				Fever or Chills
	Lack of Coordination		Sore Gums		Intolerance to heat
	Nervousness		Sore Throat		Intolerance to cold
	Anxiety		Sore Mouth or Tongue		Excessive Hunger
	Depression		Sensitive Teeth		Inability to gain weight
	Mood Swings		Impairment /Loss of sense of taste		Change or loss of sensation
	Restlessness		Increase/Decrease of saliva		Loss of Balance
	Fitful Sleep		Persistent hoarseness		Seizures or Epilepsy
	Hallucinations		Difficulty speaking		Shaking or Trembling
					Lightheadedness upon standing
	Muscle Cramps		Dry Eyes		Severe Headaches
	Muscle Weakness		Damp Eyes		Fainting Spells
	Joint Pain, Stiffness/ Swelling		Caked or crusted eyelids		Trauma or Injury to the head
	Neck Pain		Sensitivity to Light		
	Upper Back Pain		Poor eyesight		Asthma
	Lower Back Pain		Cataracts		Emphysema
	Frequent Fracturing of Bones		Glaucoma		Bronchitis
			Changes in vision		Tuberculosis
	Abdominal Bloating		Double vision		Discharge from throat with blood/mucus
	Excessive lower bowel gas		Blurred vision		Chest Pain at rest
	Stomach pain 5-6 hrs from meals		Loss of vision		Chest Pain at play
	Symptoms relieved by drinking milk		Eye pain		Heart murmur
	Symptoms aggravated by worry/tension				Heart palpitation
			Post nasal drip		Swelling of Ankles
	Constipation		Sinusitis		Rheumatic Fever
	Diarrhea		Discharge from Nose		Sleep in an upright position
	Rectal Pain		Discharge from nose during/after meal		Frequently awake at night short of breath
	Hemorrhoids		Nose Bleeds		
	Jaundice		Difficulty breathing through nose		Frequent Urination
	Hepatitis		Impairment/loss of sense of smell		Frequent Night Urination
	Gall bladder problems		Frequent/Daily coughs		Frequent Urgent
	Difficulty swallowing		Frequent Colds		Painful Urination
	Vomiting		Shortness of Breath at rest		Difficulty Holding Urine
	Vomiting blood		Shortness of Breath at play		Frequent Urinary Infections
			Wheezing		Kidney Stones
	Loss of appetite				Anemia
	Frequently awake at night hungry		Frequent/Severe nausea		Black stools
	Irritable if late for a meal		Discomfort after fatty/greasy meals		Yellow stools
	Sudden cravings for sweets or alcohol		Lack of energy after meals		Blood in stools
	Headaches/tremors relieved by eating sweets.		Frequent heartburn/indigestion		Malodorous stools
			Frequent Stomach/Abdominal pain		Anal itching
	Swollen or Painful Lymph Nodes		Frequent/excessive belching		Easily Bruised

PERSONAL HEALTH HISTORY Please indicate any condition(s) of past or present concern:

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
___	___	Alcoholism	___	___	Heart Disease
___	___	Anemia	___	___	Heart Murmur
___	___	Arthritis	___	___	High Blood Pressure
___	___	Asthma	___	___	Injury (Life-Threatening)
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Kidney Disease
___	___	Cancer	___	___	Liver Disease
___	___	Constipation	___	___	Lyme disease
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

FAMILY HEALTH HISTORY

Is any blood relative or member of your immediate family presently experiencing any of the following conditions? Please use the following codes to denote the person affected. ***M*** for your Mother. ***F*** for your Father. ***B*** for your Brother. ***S*** for your Sister. ***GM*** for your Grandmother. ***GF*** for your Grandfather. ***A*** for your Aunt. ***U*** for your Uncle. ***W*** for your Wife. ***H*** for your Husband. ***SO*** for your Significant Other.

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
___	___	Alcoholism	___	___	Heart Disease
___	___	Anemia	___	___	Heart Murmur
___	___	Arthritis	___	___	High Blood Pressure
___	___	Asthma	___	___	Injury (Life-Threatening)
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Kidney Disease
___	___	Cancer	___	___	Liver Disease
___	___	Constipation	___	___	Lyme disease
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

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I hereby authorize the payment of medical benefits directly to my physician. I authorize my physician to release any information acquired in the course of my examination or treatment that may be required; by other medical professionals; by my insurance company and its agents to determine benefits payable for services rendered; and in a collection situation.

I understand and agree that I am ultimately responsible for the balance of my account for any and all professional services rendered on my behalf regardless of statements made by any/all insurance companies that I am/was a participating member. I understand that giving you my insurance information does not guarantee insurance approval or payment and I accept full responsibility for the payment of services if my medical insurance provider does not pay as well as late fees or service charges.

SIGNED _____ DATE _____/_____/_____

Patient, Parent or Guardian's Signature (if patient is a minor)