NATURAL HEALTH ASSOCIATES
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PATIENT INFORMATION (Please Print)

Name________________________________Age_____Date of Birth______________Gender F___M___

Address________________________________City________________ST_____Zip________________

Home Phone#_________________________Cell#_________________SS#______________________

Name of Employer____Work#______________________

Employer's Address_____________________________________Occupation______________________

If married, name of spouse__________________________________Work#______________________

If minor, name of parent/guardian(s)____

Whom may we contact in case of an emergency?____

Home#____________________________Work#______________Relationship_____________________

Do you have a Primary Care Doctor? ___yes ___no ________other

If yes, please print Name or Clinic____

Whom may we thank for referring you?____

I understand and agree that (**regardless of my insurance status**), I am responsible for the balance on this account for any services, medications, or laboratory work, collection and/or attorney fees.

SIGNATURE____DATE_________________

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INSURANCE INFORMATION

(Anthem Blue Cross, Connecticare and Oxford ONLY) ***Please contact your PCP for a referral if required.***

Name of Insurance Company____

I.D.#________________________________Group#______________**Referral Required?**_____

Name of Insured(if different from patient)___________________SS#___________________

I authorize any holder of medical information about me release to HCFA and its agents, or any other supplier of medical benefits, any information needed to determine those benefits , or the benefits payable for related services. I request that payment of authorize benefits be made on my behalf to Natural Health Associates, P.C for any services furnished me by Natural Health Associates, PC

SIGNATURE______________________________________DATE______________

ADULT SYMPTOM SURVEY

NAME____**DATE**__________________
What is your major complaint? ____
____
____
Are you coming for any specific therapy? (i.e. homeopathy, acupuncture, nutritional counseling, physical medicine, "anything that works")____
____

This survey will help us to evaluate you more completely. Please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. Include all the complaints which are familiar to you. If there are one or more words in a line which describe your specific problem you may want to circle those words.

NOW	PAST	GENERAL SYMPTOMS
_____	_____	tired, weak, lack of energy
_____	_____	depression, melancholy, moodiness
_____	_____	worry, anxiety, nervousness, irritability
_____	_____	sleeplessness or sleep too much
_____	_____	frequent colds or other illness
_____	_____	headaches
_____	_____	don't sweat enough
_____	_____	sweat too much
_____	_____	night sweats
_____	_____	dizziness, fainting, convulsions
_____	_____	loss or gain of weight
_____	_____	other____________________________

NOW	PAST	SKIN AND HAIR
_____	_____	acne or pimples
_____	_____	skin rashes
_____	_____	hives
_____	_____	stretch marks
_____	_____	skin ulcers or sores
_____	_____	dryness, roughness or scaling skin, scalp, elbows, knees, feet, around nose, ears, eyebrows, etc.
_____	_____	hair loss or thinning
_____	_____	dry, coarse hair or split ends
_____	_____	bruise easily
_____	_____	nails weak, ridged or split easily
_____	_____	brown spots or bronzing on skin
_____	_____	moles, warts or skin tags
_____	_____	sunburn easily
_____	_____	cuts heal slowly or scar badly
_____	_____	flush easily
_____	_____	hands or feet numb or tingling
_____	_____	feet burn
_____	_____	athletes foot
_____	_____	other_________________________

NOW	PAST	RESPIRATORY
_____	_____	cough frequently
_____	_____	spitting up mucus or blood
_____	_____	difficulty breathing
_____	_____	shortness of breath on exertion
_____	_____	chest pain
_____	_____	other_________________________

NOW	PAST	EYES
_____	_____	nearsightedness or farsightedness
_____	_____	blurred or failing vision
_____	_____	dry, burning or itching eyes
_____	_____	eyes water excessively
_____	_____	eyes sensitive to light
_____	_____	night blindness
_____	_____	bloodshot or puffy eyes
_____	_____	other________________________

NOW	PAST	EARS
_____	_____	earaches
_____	_____	noises or ringing in ears
_____	_____	ear discharges
_____	_____	loss of hearing
_____	_____	lots of wax
_____	_____	other________________________

NOW	PAST	NOSE AND THROAT
_____	_____	hay fever, sinusitis, runny nose
_____	_____	dry mouth or nose
_____	_____	nosebleeds
_____	_____	cracks in corners of mouth
_____	_____	dry or chapped lips
_____	_____	sore throats or tonsillitis
_____	_____	clear throat often
_____	_____	sore, red or cracked tongue
_____	_____	cold sores or herpes
_____	_____	inability to smell or taste
_____	_____	lots of cavities
_____	_____	bleeding gums
_____	_____	hoarseness
_____	_____	other_________________________

NOW	PAST	MUSCULO-SKELETAL
_____	_____	muscle pain or stiffness where?_____________________
_____	_____	swollen, painful or stiff joints
_____	_____	bone pains
_____	_____	painful feet, ankles or calves
_____	_____	tremors or twitches
_____	_____	loss of strength
_____	_____	hernia
_____	_____	muscle wasting
_____	_____	other_________________________

NOW	PAST	**GASTROINTESTINAL**	NOW	PAST	**CARDIOVASCULAR**
_____	_____	loss of appetite	_____	_____	heart beats fast or irregularly
_____	_____	gagging, difficulty swallowing	_____	_____	tightness in chest
_____	_____	nausea or vomiting	_____	_____	discomfort at high altitude
_____	_____	bad breath	_____	_____	dizzy or weak upon standing up
_____	_____	metallic or bitter taste in mouth	_____	_____	swollen feet, ankles or legs
_____	_____	food cravings or strong desires	_____	_____	cold hands or feet
_____	_____	can't eat fats	_____	_____	hands or feet turn blue
_____	_____	heartburn	_____	_____	blue fingernails
_____	_____	indigestion or distress	_____	_____	leg pains when walking
_____	_____	heaviness after eating	_____	_____	varicose veins
_____	_____	belching or gas	_____	_____	tendency to anemia
_____	_____	bloating	_____	_____	high blood pressure
_____	_____	stomach or abdomen tender or painful	_____	_____	low blood pressure
_____	_____	symptoms relieved by eating	_____	_____	other________________________
_____	_____	symptoms worse after eating			
_____	_____	avoid certain foods	NOW	PAST	**URINARY**
_____	_____	headache, dizziness or irritability if skip meal	_____	_____	difficulty urinating
			_____	_____	urinate frequently at night
_____	_____	diarrhea or loose stools	_____	_____	bedwetting
_____	_____	constipation	_____	_____	incomplete urination or dribbling
_____	_____	change in bowel movements	_____	_____	pain when urinating
_____	_____	light colored or greasy stools	_____	_____	bladder infections
_____	_____	dark stools or blood in stool	_____	_____	kidney infections
_____	_____	feeling of incomplete evacuation	_____	_____	kidney stones
_____	_____	undigested food in stool	_____	_____	lower back pain
_____	_____	foul odor of stool or gas	_____	_____	other_______________________
_____	_____	hemorrhoids			
_____	_____	other_________________________			

NOW	PAST	**MALE**	NOW	PAST	**MALE**
_____	_____	prostate problems	_____	_____	diminished sexual desire
_____	_____	difficult or unusual urination	_____	_____	excessive sexual desire
_____	_____	discomfort or pain in genital area	_____	_____	difficulty maintaining an erection
_____	_____	other____			

NOW	PAST	**FEMALE**	NOW	PAST	**FEMALE**
_____	_____	irregular menstruation	_____	_____	hot flashes
_____	_____	pain prior to or with periods	_____	_____	diminished sexual desire
_____	_____	depressed, tense or irritable around periods	_____	_____	excessive sexual desire
_____	_____	painful or swollen breasts	_____	_____	difficulty having orgasm
_____	_____	lumps in breasts	_____	_____	inability to conceive
_____	_____	discharge from breasts	_____	_____	number of pregnancies
_____	_____	symptoms occur in monthly pattern	_____	_____	number of children
_____	_____	pain, discomfort or itching in genital area	_____	_____	miscarriages or abortions
_____	_____	vaginal discharge	_____	_____	other________________________

Date of last period___________________ # of days_____________ length of cycle__________________________
Date of last PAP smear_______________ Have you ever had an abnormal PAP? ____________________________
Present type of birth control_____________________Have you ever used birth control pills or an IUD? _________
What type and for how long?____

Is your diet?

____typical American ____Kosher
____vegetarian ____fast food
____vegan ____low fat
____macrobiotic ____other

Do you get regular exercise?

what? how often?

____
____
____

Do you use any of the following?

____cigarettes or tobacco ____packs per day
____coffee or black tea ____cups per day
____marijuana or other drugs ____times per week
____alcohol ____times day/week

Are you allergic to anything? Include food, plants medications, pollens, insects, MSG, chemicals, etc.

____
____

Please list any vitamins or medication which you are taking. Use the back of the page if necessary

VITAMINS OR MINERALS

____
____
____
____

PRESCRIPTION MEDICINES

____
____
____
____

HERBS OR FOOD SUPPLEMENTS

____
____
____

OVER-THE-COUNTER MEDICATIONS

____
____
____

Have you ever been hospitalized or had surgery, a serious illness or accident?

what when where

____
____

Have you or any of your family members had any of the problems in this chart? Please indicate who has had which problems by checking the appropriate space.

	Thyroid problems	Diabetes	Tuberculosis	Hypoglycemia	Stroke	Heart Attack	Epilepsy	Cancer	Asthma	Allergies	Anemia	Migraines	Hepatitis	Heart disease	Birth Defects	High Blood Pressure	Gall Bladder Disease	Arthritis	Alcoholism/addictions
Self																			
Children																			
Mother																			
Father																			
Sister(s)																			
Brother(s)																			
Grandparents																			
Others																			

Thank you for taking the time to fill out this questionnaire. For additional comments use the other side.