

Naturopathic Health Center of San Diego

11939 Rancho Bernardo Rd #120 • San Diego, CA 92128 • ph: (858) 618-5449

Confidential Patient Information

Date: _____

Name: _____ Sex: M F Age: ____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insurance _____ PPO HMO Other (please specify) _____

For the following phone numbers please indicate, by placing a check mark on the line, which numbers we can leave a message for you, identifying ourselves by the clinic name or doctor's name.

Home phone: (____) _____

Work phone: (____) _____

Cell phone: (____) _____

Other phone: (____) _____

E-mail: _____

Occupation: _____

Employer: _____

Person to be notified in case of emergency: _____

Relationship: _____

Address: _____

Phone: _____

How did you learn about our clinic? _____

Major Complaint

List the main problem (s) you are having or the reason for your appointment. If a diagnosis was made, please indicate date of diagnosis and who or where it was diagnosed.

Date of last complete check up: (physical exam and blood testing): _____

List names of current health providers (and contact information). Please indicate with a check mark next to that person's name, allowing us to contact that person if necessary.

Do you have any goals, concerns or thoughts about your healthcare that we can help you work at?

What area are you most willing to change to improve your health: **(circle all that apply)**

Diet Exercise Stress reduction Lifestyle Family or Friend relationships

Past Medical History

List any childhood illnesses or hospitalizations and your approximate age at the time of diagnosis:

Chronic or recurrent illnesses as an adult: _____

Surgeries: _____

Major and minor accidents (including car accidents) _____

Medications and Supplements

List medications and their dosage taken on a regular basis:
(Include over-the-counter medications)

Supplements
(Vitamins/Herbs/Homeopathics)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies to medications? _____

Allergies to foods _____

Environmental or Inhalant allergies _____

Indicate which of the conditions you have suffered from in the past or currently: (use a check mark)

Past	Currently		Past	Currently	
		High blood pressure			Heart burn
		Stroke			Ulcer
		Angina			Flatulence (gas)
		Fatigue with slight exertion			Bloating after meals
		Heart palpitation			Abdominal pain
		Heart murmur			Difficult digestion
		Heart defect (type) _____			Pain with bowel movement
		Cold hands or feet			Hemorrhoids
		Swelling of feet or ankles			Colon Problems
		Varicose veins			Blood in stool
		Nose bleeds			Mucous in stool
		Chronic cough			Dry skin
		Frequent colds			Dry hair
		Hypothyroidism			Hair loss on scalp
		Hyperthyroidism			Hair loss arms or legs
		Excessive fatigue			# times waking up to urinate _____
		Muscle cramps			Kidney infections
		Back pain			Kidney stones
		Neck pain			Frequent urination
		Joint pain (location) _____ _____			Bed wetting
		Swollen joints			Dribbling after urination
		Decrease in height			Increase in thirst
		Spinal curvature			Increase in appetite
		Asthma			Sugar cravings
		Eczema			Mood swings
		Hay Fever			Sadness
		Difficulty breathing			Difficulty sleeping
		Other respiratory disorder _____			Change in vision
		High cholesterol			Loss of coordination
		Broken bones (list) _____ _____			Anemia (type if known): _____
		Easy bruising			Headaches
		Difficulty hearing			Memory loss

Personal/Social: Height: _____ Current weight: _____

Do you drink alcohol? Yes No # of alcoholic drinks _____ per day week month (circle one)


Do you smoke tobacco? Yes No _____cigarettes packsper day (circle one)
of years you have smoked _____

Family History: check all that apply, and indicate family member's relation to you (i.e. maternal aunt).

If family member has passed away from any of the following, please indicate their approximate age at the time of their passing.

- Diabetes _____
- Heart disease _____
- Stroke _____
- Heart Attack _____
- Alzheimer's disease _____
- Other neurological disease(indicate) _____
- Hypertension _____
- High Cholesterol _____
- Osteoporosis _____
- Cancer(Type) _____
- Chronic Gastrointestinal Disease (i.e. Crohn's Disease, Ulcerative Colitis, Peptic Ulcers, Reflux)
Indicate which of the above or any other _____
- Asthma _____
- Emphysema (or other chronic respiratory disorder) _____
- Chronic Skin condition (i.e. Psoriasis, eczema, rosacea) _____
- Alcoholism _____
- Depression _____

Fax this and any other forms to (858) 618-5954

 **Initial here** _____ indicating that you have read and agree to the terms of our first appointment information on the following page.

First appointment Information (Please do not fax this page)

Directions can be found at www.SanDiegoNaturalHealth.com click on the Office visits tab, and then “Contact/Directions”

Our address is 11939 Rancho Bernardo Rd., Suite 120, Rancho Bernardo 92128
Phone (858) 618-5449.

- **24 hours notice of cancellation:**

We require 24 hours notice of cancellation for all appointments and telephone consults. Cancellations made without 24 hours notice from the scheduled time of their appointment will be charged a cancellation fee. Monday appointments must be cancelled no later than Friday 5pm. New patients appointments are charged \$110 if they miss their appointment or cancel with less than 24 hours notice.

- **Please be on time for your appointment:**

If for some reason you are running late, please call us to let us know you are on your way. Those who arrive more than 10 minutes late for their appointment may have to reschedule their appointment and a missed appointment fee will be charged. The doctor has the option to see the patient should they arrive late, however this depends upon availability of the doctor's Schedule. Those who arrive late whose appointments are kept may be charged according to the time the appointment was scheduled for.

- **What to Expect at Your First Visit**

Your doctor will be gathering information from you to make an appropriate treatment plan or to decide what labs to order. Based on the length of the visit or need for labs to be ordered, you may not receive any treatment plan at your first visit.

- **Copies of Medical Reports and Laboratory reports:**

We ask that you make copies of any pertinent previous lab reports before your visit and bring them with you. We will ask that you leave this copy with us so that we can keep it in your chart. ***Please do not fax them***

- **Supplements and Medications:**

If you would like us to review the supplements you are on please bring the supplement bottles with you to your visit and accurately write down or print out the product information. You may also do the same with your medications. Please be sure to double check that the medications listed on the intake form are accurate with the correct dosages.