

Glastonbury Naturopathic Center LLC

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Dr. Helene Pulnik, ND
Naturopathic Physician

New Patient Questionnaire

Please fill out this form completely, sign the first & last pages, and bring to your appointment

IF YOU CANNOT KEEP YOUR APPOINTMENT, PLEASE GIVE 24 HOURS ADVANCE NOTICE

Your Appointment Date and Time;

Please complete all of the following sheets before you come in for your visit. You may put "none" or "not applicable" but please fill in all questions on all pages and bring any relevant medical records or copies of laboratory tests.

Name _____ Date of birth ____/____/19____

Guardian (if minor) _____

Address _____

City _____ State _____ Zip code _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Sex _____ Marital status: married / single / divorced / separated / significant other

Social Security # _____ Occupation _____

Employed by _____

PRIMARY CARE DOCTOR/PCP _____ Date Last Seen _____

Primary Insurance _____

Insurance Address _____ Phone # _____

Member ID # _____ Group # _____

**Subscriber/Policyholder Name _____ Your Relationship to Subscriber _____

**Subscriber/Policyholder DOB _____ Social Security # _____

Please tell us how you found out about our office? _____

Patients with Blue Cross Insurance Plans: We participate in several Blue Cross Insurance plans. However, some Blue Cross plans do not cover our services and it is your responsibility to call your Blue Cross carrier before your first visit to confirm that your visit will be covered under your plan. If a referral is required, you are responsible for obtaining it before the visit. If you have other insurance, you will be provided with a

The patient is responsible for submitting the Superbill to their insurance company for reimbursement.

****INSURANCE REFERRALS:** If required by your insurance provider, it is the patient's responsibility to obtain a referral prior to the first visit.

Payment for services is expected in full at the time they are rendered.
Payments may be made by Cash, Check, Master Card, Visa, Discover
or American Express

We do NOT participate in Federal Employee Blue Cross, Medicare or Medicaid or any Blue Cross/Medicaid or Medicare

****Medi-Gap and Over-65 Blue Cross plans do not cover our services.****

CHIEF COMPLAINT: Describe in detail your chief problem or primary reason for seeking our help. Include the location / duration / timing-when did this problem begin / severity / context / modifying factors / associated symptoms / factors that make it better or worse.

S:CURRENT MEDICAL PROBLEMS: Please describe all **other** current health problems or symptoms you'd like to address.

1)

2)

3)

4)

5)

Blood Type (circle): **A** **B** **O** **AB** **RH: -- +**

S:PAST MEDICAL HISTORY: List all medical or psychiatric problems, hospitalizations, major injuries/trauma or surgery you have had in the past: (put NONE, if applicable)

Date Illness / Surgery Name of Doctor/ Hospital Treatment / Complications

1)

2)

3)

4)

Childhood Illnesses	Scarlet Fever Y/N	Mumps Y/N	Measles Y/N
Chicken Pox Y/N	Rheumatic Fever Y/N	Diphtheria Y/N	German Measles Y/N

Immunizations

Polio Y/N	Pertussis Y/N	Tetanus Y/N last Tetanus booster ____/____/____
Diphtheria Y/N	Measles/Mumps/Rubella Y/N	Chicken Pox Y/N
Hepatitis B Y/N	Anthrax Y/N	

Physician Signature _____ **DATE** _____

S:HEALTH PROFILE/Review of Symptoms

Please place a checkmark next to those symptoms which you NOW experience. Feel free to write in comments or circle specific symptoms.

General

- Tired, weak, lack of energy
- Headaches
- Faintness
- Dizziness
- Insomnia
- Recent weight loss or gain
- Frequent colds or infections
- Unusual sweating/night sweats

Eyes

- Watery or itchy eyes, Burning eyes
- Swollen, reddened or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision

Ears

- Itchy ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

Nose

- Post Nasal Drip**
- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation
- Nose Bleeds

Mouth/Throat

- Chronic coughing
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen/discolored tongue, gums, lips
- Canker sores/Herpes lesions
- Swollen Glands
- Bleeding Gums/Gum disease
- Cracks in corners of mouth

Skin/Hair

- Acne
- Hives, rash
- Moles, warts, skin tags
- Bruise Easily
- Cuts heal slowly
- Nails weak, ridged or split easily
- Dry, coarse, rough skin
- Dandruff
- Eczema/Psoriasis
- Hair loss/Hair thinning
- Flushing or hot flashes
- Excessive sweating

Digestive Tract

- Diarrhea
- Nausea or vomiting
- Constipation
- Hemorrhoids
- blood in stools
- Upper Abdominal pain
- Lower Abdominal pain
- Bloating feeling
- Belching or passing gas
- Heartburn
- Indigestion

Joints/ Muscles

- Pain or aches in Joints
- Low back pain
- Arthritis/Bursitis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness
- Poor physical coordination

Weight

- Binge eating/drinking
- Craving of certain foods
- Unable to loose weight**
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

Energy / Activity

- Daytime sleepiness/excessive sleeping
- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

Mind

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Difficulty making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

Physician Signature _____ **DATE** _____

- ___ Athlete's foot/jock itch
- ___ Cold Hands and Feet
- ___ Burning Feet
- ___ Numbness/Tingling in Hands/Feet

Heart

- ___ **Anemia**
- ___ Irregular or skipped heartbeat
- ___ Rapid or pounding heartbeat
- ___ Chest pain/tightness
- ___ High Cholesterol
- ___ Prolapsed Mitral Valve
- ___ Pacemaker
- ___ Swollen feet/ankles
- ___ Varicose Veins
- ___ Leg/calf pains when walking
- ___ Shortness of Breath
- ___ Blue fingernails
- ___ Hands/Feet turn blue
- ___ Dizzy or weak when stand up from lying/sitng

Emotions

- ___ Mood swings
- ___ Anxiety, fear, nervousness
- ___ Depression
- ___ Anger, irritability, aggressiveness

Lungs

- ___ Chest congestio
- ___ Asthma, bronchitis
- ___ Shortness of breath
- ___ Difficulty breathing (at rest? With exertion?)
- ___ Coughing up blood/mucus
- ___ Emphysema
- ___ Present Smoker ___ packs/day for ___ years
- ___ Past Smoker ___ packs/day for ___ years
- ___ Exposure to Passive Smoke in past ___ present ___

Urinary

- ___ Frequent or urgent urination
- ___ Urinate frequently at night
- ___ Incomplete urination/dribbling
- ___ Pain/burning while urinating
- ___ Bladder/Urinary tract infections
- ___ Kidney stones

Male

- ___ Prostate problems
- ___ Difficult urination
- ___ Discharge
- ___ Infertility
- ___ Other

Female

- ___ Irregular menstruation
- ___ Painful periods
- ___ Infertility
- ___ Breast lumps
- ___ Vaginal discharge
- ___ Nipple discharge
- ___ pain before periods
- ___ Nausea/vomiting with periods
- ___ Hot flashes
- ___ Night sweats

Do you have high blood pressure? _____ Low blood pressure? _____

How many hours of sleep do you need? _____ Do you wake tired? _____

Energy level on Scale from 1-5 (5 being fantastic) _____

What time of day do you have the most energy? _____ Least energy? _____

Take naps? _____ Do you feel better or worse after exercise? _____

Are you generally Energized or Exhausted? Describe _____

Do you have difficulty tolerating cold or hot weather? _____

Which do you prefer? _____ Do you get cold/chilled easily? _____

Cold hands and feet? _____ Frequency of bowel movements _____

Physician Signature _____ **DATE** _____

S: MEDICATIONS AND SUPPLEMENTS:

Please list ALL Medications you are currently taking:

<u>NAME of DRUG</u>	<u>DOSE</u> (_mg)	<u>FREQUENCY</u> -how often taken
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Vitamins/minerals, herbal medications, homeopathic remedies or other supplements you are currently taking:

<u>NAME of SUPPLEMENT</u>	<u>DOSE</u> (_mg)	<u>FREQUENCY</u> -how often taken
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Medications or supplements taken in the past and your response, especially what has NOT worked:

ANY ALLERGIES TO: Please indicate type of reaction

Medications:

Foods:

Inhalants (dust, grass, hay fever, animals, molds):

Chemicals (Do perfume, smoke, auto exhaust bother you?)

S: FOR WOMEN ONLY:

Last Normal Menstrual Period _____ Last Mammogram _____ Results _____

Are your cycles regular/irregular? _____ Number of days between cycles? _____

Is the menstrual flow light/ normal /heavy? _____ How many days does it last? _____

Premenstrual symptoms? _____ Water retention _____ Weight gain _____ Breast tenderness _____

Irritability/mood swings _____ Pain/Cramping Before/During Periods? _____

Age when your period started? _____ History of STDs? _____

Last Pap smear _____ Results _____ Any Abnormal Paps? _____

Treatment for Abnormal Paps _____

Number of pregnancies _____ Number of children _____ Miscarriages/abortions _____

Any complications of pregnancy /labor/delivery? _____

Any Gynecological or Breast surgeries or procedures? _____

Menopause – age (onset) _____ Taking Hormone Replacement Therapy? _____

Hot flashes or other menopausal symptoms? _____

Method of Contraception _____

FOR MEN ONLY

Prostate Problems? _____

History of STDs? _____

Other _____

Physician Signature _____ DATE _____

S:FAMILY MEDICAL HISTORY - Please list any history of:

Cancer (Type) High Blood Pressure Thyroid Problem Diabetes Mental or Other Illness Deceased? What Age?

Mother _____

Father _____

Maternal Grand Mother _____

Maternal Grand Father _____

Paternal Grand Mother _____

Paternal Grand Father _____

Birth Order: # _____ Of _____ Children

Brothers _____

Sisters _____

Spouse _____

Children (Ages) _____

Other family information: _____

With whom do you live ? _____

Do you have any pets? (describe) _____

NUTRITION Do you consume:

How often?

_____ Caffeinated coffee, soda, or tea? _____

_____ Soft drinks? _____

_____ Fresh fruit and vegetables ? _____

_____ Fried foods/ fast food restaurants _____

_____ Alcoholic beverages? _____

_____ Sugar/sweets? _____

_____ Crave salty foods? _____

_____ Six glasses of water each day? _____

_____ Smoke cigarettes, cigars, pipe? _____

_____ Recreational Drugs _____

What type of exercise do you participate in regularly? _____

How often? _____ Do you enjoy it? _____

Describe your diet on a typical day. Include portion sizes:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Physician Signature _____

DATE _____