New England Naturopathic Medical Center, LLC

New Patient Profile

Date:____________

Last Name:______________________________ First Name:_____________________________ Birth date:____/____/_____

Address:____ Home Phone:_________________________________

City:________________________ State:________ Zip:_____________ Work Phone:__________________________________

Emergency Contact:________________________ Social Security Number:______-_____-________ OK to call work? Y / N

Insurance Information

Insurance Company:_______________________ Policy ID #_________________________ Group #____________________

Name of Insured:___________________________ Insured's Employer____

Insurance Authorization

Authorization to Pay Doctor

I hereby authorize the ____insurance company to pay, by check made out to and mailed directly to:

New England Naturopathic Medical Center, LLC
Dr. Lesa Werner, ND

West Hartford, CT 06119

Print Name:________________________________ Signature:_________________________________ Date:_______________

Authorization to Release Information to Insurance Company

I hereby request and authorize the disclosure, whenever requested to do so, either verbally or in writing, any information which you may deem appropriate concerning my physical condition with respect to any illness or injury, medical history, consultation or treatment. I hereby release Dr. Lesa Varnagy from all legal responsibility, liability or consequence thereof, which may arise from the act that I have authorized above.

Print Name :_______________________________ Signature :________________________________ Date :______________

Dr. Lesa Werner
415-755-7639

New Patient Profile

Date:________________

Last Name:______________________________ First Name_________________ M / F______ Birth date:______/_____/_____

A note to our patients: Please complete this questionnaire as thoroughly as possible to assist the doctor in your treatment. This information is *confidential* and will not be released without your expressed written consent.

PRESENT HEALTH CONCERNS

Please list health concerns in order of their significance.	Has this problem been previously diagnosed? If so, what was the diagnosis?
1.	1.
2.	2.
3.	3.

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

____ ____

____ ____

____ ____

____ ____

Bring all prescriptions and supplements in original bottles to your office visit.

LIST ALL SUPPLEMENTS, HERBS, AND HOMEOPATHICS YOU ARE CURRENTLY TAKING:

____ ____

____ ____

____ ____

____ ____

LIST ALL ALLERGIES TO MEDICATIONS: ____

____

LIST ALL PREVIOUS SURGERIES____

Medical Diagnostic Exams/Labs/Screenings: Please list approximate dates and results below

PAP Smear Date: ______________ Result:____

EKG/ Stress Test Date: ______________ Result:____

Blood Work Date: ______________ Result:____

Mammogram Date: ______________ Result:____

Chest X-ray Date: ______________ Result:____

Urinalysis Date: ______________ Result:____

DEXA / Bone / Density Scan Date: ______________ Result:____

Colonoscopy Date: ______________ Result:____

Last Menstrual Period Date: ____

Please bring a copy of all recent labs and imaging studies with you to your appointment

Family Medical History: Please indicate if any family members have had any of the following conditions: (**M**= mother; **F**= father; **S**=sister; **B**=brother, **GM-M**= maternal grandmother; **GM-P=** paternal grandmother; **GF-M=**maternal grandfather, **GF-P=** paternal grandfather; **C=** your children))

Allergies_____________________ Diabetes_____________________ Hypoglycemia________________

Alcoholism___________________ Endocrine/hormone ___________ Kidney disorder_______________

Asthma______________________ Genetic/ Congenital / Inherited condition_____________________ Liver problems________________

Bleeding tendency_____________ Heart disease________________ Neurological disorder__________

Cancer /Type_________________ High Blood Pressure___________ Tuberculosis_________________

Depression/Anxiety____________ High Cholesterol_______________ Other______________________

Patient Symptoms Checklist: Please indicate if you currently **(C)** suffer from any of the following, or if you have suffered from a condition in the past **(P):**

Alcoholism_____	Diabetes_____	Hemorrhoids_____	Shakiness if hungry_____
Acne_____	Diarrhea_____	Hot flashes_____	Sciatica_____
Asthma_____	Dizziness_____	Insomnia_____	STD history_____
Anemia_____	Dry skin_____	Interrupted sleep_____	Sinus problems_____
Anxiety_____	Dry/ Brittle nails_____	Irregular Menses_____	Skin problems_____
Arthritis_____	Ear pain/ringing_____	Joint pain_____	Stroke_____
Back pain_____	Eye pain_____	Kidney/pain/infection_____	Spine problems_____
Bad breath_____	Visual changes_____	Leg pain_____	Tremor_____
Bloating/Gas_____	Fatigue_____	Lumps in breast_____	Tuberculosis_____
Bruise easily_____	Fluid/water retention_____	Mood Swings_____	Ulcers_____
Bursitis_____	Foot pain_____	Nausea_____	Vaginitis_____
Bloody stools_____	Forgetfulness_____	Neck pain_____	Varicose veins_____
Cancer_____	Frequent colds_____	Night sweats_____	Weight gain_____
Chest pain_____	Frequent urination_____	Nosebleeds_____	Weight Loss_____
Chronic fatigue_____	Hay fever_____	Numbness/tingling_____	Yeast infections_____
Cold hands/feet_____	Headaches	Mucus/Phlegm_____	Other_____
Constipation_____	HIV_____	Poor Circulation_____	______________________
Cough_____	Herpes/cold sores_____	PMS_____	______________________
Cramps_____	Heartburn/GERD_____	Poor digestion_____	______________________
Decreased Sex drive_____	Heart palpitations_____	Prostate issues_____	______________________
Depression_____	High Blood Pressure_____	Shortness of Breath_____	______________________

Diet: Please describe a typical Breakfast, Lunch and Dinner.

Breakfast:
Snack:
Lunch:
Snack:
Dinner:
Snack:

How much water do you drink per day?____

How much coffee do you drink per day?____

How much alcohol do you drink per day/week?____

Exercise: Describe the amount and type of exercise you participate in on a weekly basis?

___

Sleep: Describe your sleep. (Hours per night, interrupted sleep, sound sleep, difficulty falling asleep, etc.)

___

Environmental: Please list any chemicals, fumes, dust particles, pesticides or other toxins to which you are exposed.

___

Smoking: Do you smoke or are you exposed to smoke? If so, how much and for how long?

___

Stress: Are you frustrated by your current situation (home, work, family, relationships)?

___

Sex: Are you currently in a committed relationship?

___

Do you practice safe sex?

___

Spiritual:

Do you have a religious/spiritual orientation/practice that is important to you? Are there any products that the doctor might suggest that may be against your beliefs (e.g. Non-Kosher products, animal-based vs. vegan products, digestive enzymes derived from pork?). Please elaborate freely (note: our office can accommodate various food/religious concerns that you might have):

___

___

___

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS EXTENSIVE FORM. YOUR EFFORT WILL ASSIST THE DOCTOR IN DETERMINING AN ACCURATE DIAGNOSIS AND APPROPRIATE INDIVIDUALIZED TREATMENT PLAN.