Dr. Erica Waters, ND
401 Court St
Brooklyn, NY 11231
(516) 864-3893
EWatersND@gmail.com

Name Date

Age Date of Birth / / Gender:

Address

City State Zip Code

Telephone # (home or cell) (work)

Email:

Occupation Hours per week Retired

Employer

(Work address)

Married Separated ___ Divorced _____ Widowed _____ Single

Partnership

Live with: Spouse ____ Partner Parents _____ Children

Friends _____ Alone

Who referred you ?

What are your most important health concerns? List as many as you can in order of importance.

1)

2)

3)

4)

Past Medical History

Please check any of the following that pertain to you

	Date	For What Reason	Results
Bone Density**:**			
CT Scan:			
MRI:			
EKG**:**			
EEG:			
Colonoscopy:			
Endoscopy:			
XRay:			
Hospitalizations:			

Family History

	If living		*If deceased*	
	Age	**Health**	**Cause of Death**	**Age**
Mother :				
Father:				
Siblings:				
Children:				

Allergies

Are you hypersensitive or allergic to...

Any drugs?

Any foods?

Any environmental factors?

Current Medications

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Tobacco	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N	Sleeping pills	Y	N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) 4)

2) 5)

3) 6)

Typical Food Intake

Breakfast:

Lunch:

Dinner:

Snacks:

To drink:

GENERAL

Weight ___ lbs. Weight 1 year ago ___lbs
Maximum Weight When
Height
When during the day is your energy the best? worst?

REVIEW OF SYSTEMS

Y = a condition you have now **P** = a condition you have had before

N = never had

FOR THE FOLLOWING, PLEASE CIRCLE

MENTAL/EMOTIONAL

Mood Swings?	Y	N	P	Anxiety or nervousness?	Y	N	P
Poor concentration?	Y	N	P	Memory problems?	Y	N	P

ENDOCRINE

Hypothyroid?	Y	N	P	Heat or cold intolerance?	Y	N	P
Hypoglycemia?	Y	N	P	Diabetes?	Y	N	P
Fatigue?	Y	N	P	Seasonal depression?	Y	N	P

IMMUNE

Vaccinations?	Y	N	P	Reactions to vaccinations?	Y	N	P
Chronic Fatigue Syndrome?	Y	N	P	Chronic infections?	Y	N	P
Chronically swollen glands?	Y	N	P	Slow wound healing?	Y	N	P

SKIN

Rashes?	Y	N	P	Eczema, Hives?	Y	N	P
Acne, Boils?	Y	N	P	Itching?	Y	N	P

HEAD

Headaches?	Y	N	P	Migraines?	Y	N	P
Head injury?	Y	N	P				

EARS

Earaches?	Y	N	P	Impaired hearing?	Y	N	P
Dizziness?	Y	N	P	Ringing?	Y	N	P

NOSE AND SINUSES

Frequent colds?	Y	N	P	Nose Bleeds?	Y	N	P
Stuffiness?	Y	N	P	Hayfever?	Y	N	P
Sinus problems?	Y	N	P	Loss of smell?	Y	N	P

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	Sore tongue/lips?	Y	N	P

RESPIRATORY

Cough?	Y	N	P	Wheezing?	Y	N	P
Asthma?	Y	N	P	Bronchitis?	Y	N	P

CARDIOVASCULAR

Heart disease?	Y	N	P	High/Low Blood Pressure?	Y	N	P
Palpitations/Fluttering?	Y	N	P				

GASTROINTESTINAL

Heartburn?	Y	N	P	Belching or passing gas?	Y	N	P
Change in thirst?	Y	N	P	Change in appetite?	Y	N	P
Bowel Movements				Constipation?	Y	N	P
How often?				Diarrhea? Y	N	P	
Is this a change?							

URINARY

Increased frequency?	Y	N	P	Frequency at night?	Y	N	P
Frequent infections?	Y	N	P				

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P	Arthritis?	Y	N	P
Muscle spasms or cramps?	Y	N	P				

Male

____ ____ Prostate problems
____ ____ Discharge from Penis
____ ____ Infertility
____ ____ Erection problems
____ ____ Testicle pain or swelling
____ ____ Varicocele

Female

____ ____ Vaginal discharge
____ ____ Painful Intercourse
____ ____ Premenstrual Syndrome (PMS)
____ ____ Irregular periods
____ ____ Bleeding between periods
____ ____ Ovarian Cysts
____ ____ Menopausal problems
____ ____ Few or No orgasms
____ ____ Vaginal itching
____ ____ Heavy periods
____ ____ Long lasting periods
____ ____ Fibroids
____ ____ Endometriosis

Age menstruation began: _____ How frequent are periods: every _____ days
How long do Periods usually last? _____ days
Number of Pregnancies _____ Number of Births _____ Miscarriages _____
Abortions _____

HABITS

Do you exercise? Y N

If yes, what kind? How often?

Average 6-8 hrs. sleep?	Y	N		Enjoy your work?	Y	N	
Sleep well	Y	N		Take vacations?	Y	N	
Awaken rested?	Y	N		Spend time outside?	Y	N	
Have a supportive relationship?	Y	P		Any major traumas?	Y	N	P
Have a history of abuse?	Y	N	P				
Use recreational drugs?	Y	N	P				
Treated for drug dependence?	Y	N	P				
Do you eat 3 meals a day?	Y	N	P	Use alcoholic beverages?	Y	N	P
Do you eat out often?	Y	N	P	Treated for alcoholism?	Y	N	P
Do you go on diets often?	Y	N	P	Do you use tobacco?	Y	N	P
Do you drink coffee?	Y	N	P				
Do you drink black tea?	Y	N	P				
Do you drink cola?	Y	N	P				
Do you eat refined sugar?	Y	N	P				
Do you add salt?	Y	N	P				

Is there any information about your health you would like to add?

Email policy: Dr. Waters is happy to use email to make appointments, answer any questions prior to making an appointment, and responding to brief questions pertaining to supplements and protocol. Please reserve any detailed questions (i.e questions regarding new symptoms, changes in treatment plan, etc.) for an in-office or phone visit. If you have more than a few questions please call to set up an appointment. If you are having a negative reaction to something or have an urgent issue, please call the office.

The initial visit will be focused on your health history and current health concerns. I am committed to improving your health. Please take a moment and determine what level of commitment you are willing to make in this process. Thank you and I look forward to working with you.

Erica Waters, ND
Consent Form

I understand that Erica Waters, ND has graduated from a federally accredited four-year naturopathic medical school (National College of Natural Medicine in Portland, Oregon), that she attained the degree of Naturopathic Doctor (ND), and is a licensed naturopathic physician.

I understand that the state of New York does not recognize or license qualified naturopathic physicians. Therefore, Erica Waters, ND does not practice medicine and does not diagnose or treat disease or medical conditions in the state of New York. I understand that Erica Waters, ND functions as a health consultant and focuses her practice on the enhancement of health, and furthermore, nothing that is discussed during any visit or in any other setting is meant for the diagnosis and/or treatment of any medical condition. I also understand that the services of Erica Waters, ND are not meant to replace or be a substitute for those of a licensed physician. In addition, Erica Waters, ND requires that all clients that seek her professional consultation to be under the concurrent care of a licensed New York state physician.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship