DR. HILARY COSTELLO

HOLISTIC DERMATOLOGY ✵ NATUROPATHIC MEDICINE ✵ SKIN SURGERY

New Patient Intake Form

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

S.S.# _____ Gender: F / M

Address: _____ City: _____

State: _____ Zip: _____ Email address: _____

Tel: (home) _____ - _____ - _____ (cell) _____ - _____ - _____ (work) _____ - _____ - _____

Occupation: _____ Employer: _____

How did you hear about our medical office? _____

Please Check One: Married / Partnered:____ Separated:____ Divorced:____ Widowed:____ Single: ____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

For minors, please note parent's name, birthday and SS#: _____

Insurance Carrier: _____ Plan Name: _____

ID/Subscriber #: _____ Group #: _____

What are your most important health concerns that you would like to address and discuss today?

List in order of importance.

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

A Note To Our Patients:

It is our honor to care for you in a holistic and inspirational way. Our goal is to understand your physical health and embrace the complexity of your mental & emotional health, your spiritual connection, and all of the various aspects of your life. Our methods of diagnosis and treatment are unique to each individual and span the arts and the science of healing from modern scientific perspectives to nutrition and traditional herbal medicines. Our commitment is to provide you with excellent naturopathic care and to work together with you to help you achieve and maintain optimal health and longevity.

MEDICAL HISTORY

When and where did you last receive medical or health care? _____

For what reason? _____

Do you have a primary care physician (PCP): Y / N Name? _____

Do you receive other treatments such as acupuncture, massage, chiropractic care, aesthetics, etc? Y / N

If so, please explain: _____

What self-care practices do you use? _____

CURRENT MEDICATIONS / SUPPLEMENTS

Do you take or use any of the following? (please check all that apply)

☐ Laxatives ☐ Pain Relievers ☐ Antacids ☐ cortisone

☐ Sleeping Pills ☐ Thyroid medication ☐ Antibiotics ☐ Tranquilizers

☐ Birth Control Pills ☐ Hormone Replacement

Please list any prescription medications, over-the-counter medications, vitamins or other supplements you are currently taking. Please include dosage.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

DIET/LIFESTYLE

Current weight: _____ Weight one year ago: _____ Max weight: _____ Height: _____

Do you exercise? Y / N What forms? _____ How often? _____

Do you adhere to a specific diet? Y / N If so, what foods do you avoid?_____

Any allergies or sensitivities? _____

Please list the food you eat on a typical day:

Weekday

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

Weekend

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

Water intake daily: _____ Other Favorite Beverages: _____

Do you consume:

☐ Coffee/tea/soda _____ cups per day ☐ Alcohol _____ drinks per week

☐ Processed / Fast foods _____ times per day ☐ Sugar _____ times per day

☐ Cigarettes or tobacco _____ packs per day

Have you ever smoked or used tobacco? Y / N How much? _____ packs per day for _____ years.

On average, how many hours per night do you sleep? _____ Sleep well? _____ Awaken rested? Y / N

Religious / Spiritual / Meditative practices: _____

Please list hobbies that you enjoy: _____

_____

How many hours per day do you watch television or movies? _____ Read? _____

CHILDHOOD HEALTH INFORMATION

Childhood Information:

Birth Country: _____ State/Province: _____ Weight: _____

Were there any complications at your birth or with your mother's pregnancy? Y / N If so, please explain:

_____

Where did you grow up? _____

Have you lived outside of the U.S.A. for longer than three months? Y / N

If so, when/where? _____

Did you receive vaccines? Y / N If so, were there any complications? _____

Please check the boxes for any conditions you had as a child:

☐ Rheumatic Fever ☐ Diptheria ☐ Scarlet Fever ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Skin Conditions ☐ Anxiety

HOSPITALIZATIONS, SURGERIES & DIAGNOSTICS

For example, EKG, X-ray, CT scan, EEG, Bone Density Scan (DEXA), Mammogram, MRI

List all that apply. Please include the approximate date.

Hospitalizations: _____ _____ _____

Surgeries: _____ _____ _____

Biopsies: _____ _____ _____

Diagnostics: _____ _____ _____

Other (please include date): _____

What, if any, diagnosis was given as a result: _____

_____

FAMILY HISTORY

Instructions: Please check the boxes applicable to you and write in your answer as needed

	Father	Mother	Brother				Sister				Spouse/ Partner	Children					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Age (if Living)																	
Health Good or Bad																	
Cancer																	
Thyroid Disease																	
Diabetes																	
Heart Problems																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Mental Health Concerns																	
Asthma, Allergies																	
Arthritis																	
Age (At Death)																	
Cause Of Death																	

Grandparents / extended family members pertinent health history: _____

_____

What is your family heritage? _____

ALLERGIES

Please list your known allergies or hypersensitivities to: (use additional space at bottom of page if needed)

Medications / Drugs:

1) _____ Reaction: _____

2) _____ Reaction: _____

Foods / Drinks:

1) _____ Reaction: _____

2) _____ Reaction: _____

Environmental, chemical, latex, animal, etc:

1) _____ Reaction: _____

2) _____ Reaction: _____

PERSONAL HEALTH INFORMATION

Please **check** all significant symptoms you have experienced in the past, particularly in the past year. Please **circle** all symptoms that are extremely important to address.

General

☐ Poor appetite	☐ Cold hands and feet	☐ Fevers	☐ Chills	☐ Hearing Loss
☐ Puffiness or Swelling	☐ Fatigue	☐ Sweat Easily	☐ Night Sweats	☐ Weakness
☐ Easy to Bleed or Bruise	☐ Poor Sleep	☐ Sudden Energy Drops	☐ Tremors	☐ Strong Thirst
☐ Sweating without exertion	☐ Poor Balance	☐ Weight Loss	☐ Always Cold	☐ Always Hot
☐ Changes in Appetite	☐ Cravings	☐ Weight Gain	☐ Other	

Skin / Hair

☐ Psoriasis	☐ Hives	☐ Dry Skin	☐ Dandruff	☐ Recent Moles
☐ Eczema	☐ Acne / Pimples	☐ Recent Hair Loss	☐ Skin Cancer	☐ Rosacea

Head / Face

☐ Head Feels "Cloudy or Heavy"	☐ Poor Memory	☐ Facial Paralysis	☐ Concussions	☐ Facial Pain
☐ Frequent Headaches	☐ TMJ Pain	☐ Dizziness	☐ Lip / Tongue Sores	☐ Toothache
☐ Migraine				

Eyes

☐ Blurred Vision	☐ Cataracts	☐ Dry Eyes	☐ Eye Pain / Strain	☐ Floaters
☐ Watery Eyes	☐ Itchy Eyes	☐ Night Blindness		

Ears

☐ Ear Ringing	☐ Ear Infections	☐ Dizziness	☐ Hearing Loss	☐ Congestion

Nose / Throat

☐ Allergies	☐ Sensation of Lump in Throat	☐ Recent Sore Throat	☐ Sinus Headaches	☐ Sinus Infections
☐ Trouble Swallowing				

Respiratory

☐ Shortness of Breath	☐ Chronic Bronchitis	☐ Emphysema	☐ Phlegm	☐ Cough
☐ Asthma	☐ Lung Cancer	☐ Coughing up Blood		

Cardiovascular

☐ Previous Heart Attack	☐ Heart Palpitations	☐ High Blood Pressure	☐ Edema / Swelling	☐ Chest Pain
☐ Tightness in Chest	☐ Irregular Heart Rhythm	☐ High Cholesterol	☐ Varicose Veins	

Appetite / Thirst

☐ Crave Sweets	☐ Crave Sour Taste	☐ Crave Salty Taste	☐ Always Thirsty	☐ No Thirst
☐ Increased / Decreased Appetite				

Digestion

- ☐ Heartburn
- ☐ Chronic Gas
- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Cramping
- ☐ Gallstones
- ☐ Constipation
- ☐ Blood in Stool
- ☐ # of Stools Per Day: _____
- ☐ Diarrhea
- ☐ Food Allergies
- ☐ Mucous in Stool
- ☐ Irritable Bowel
- ☐ Vomiting
- ☐ Colitis

Genito-urinary

- ☐ Frequent Urination
- ☐ History of Frequent Infection
- ☐ Pain or Burning on Urination
- ☐ Waking at Night to Urinate
- ☐ Incontinence
- ☐ History of Sexually-Transmitted Infections (STD / STI)
- ☐ Difficulty Urinating
- ☐ Kidney Stones

Sleep

- ☐ Difficulty Sleeping (insomnia)
- ☐ Nightmares
- ☐ Muscle Cramps
- ☐ Waking Frequently
- ☐ Snoring

Energy Level

- ☐ Fatigue
- ☐ Heavy Limbs
- ☐ Restlessness
- ☐ Excessive Energy
- ☐ Difficulty Waking

Mental Health

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Sadness / Grief
- ☐ Anger / Irritability
- ☐ Fear / Worry
- ☐ Panic Attacks
- ☐ Phobias

Women's Health

- ☐ Irregular Periods
- ☐ # of Pregnancies: _____
- ☐ # of Children: _____
- ☐ Cramping
- ☐ Heavy or Light Periods
- ☐ Libido Issues
- ☐ Uterine Fibroids
- ☐ PMS
- ☐ Miscarriage
- ☐ Ovarian Cysts
- ☐ Endometriosis
- ☐ Irregular Ovulation

Men's Health

- ☐ Difficult / Unusual Urination
- ☐ Diminished or Excessive Sexual Drive
- ☐ Prostate Problems
- ☐ Erectile Dysfunction
- ☐ Testicular Mass
- ☐ Discomfort or Pain in Genital Area
- ☐ Libido Issues

MUSCULOSKELETAL PAIN

Please indicate any areas of pain or discomfort

Draw the area of your symptoms using these symbols:
(please mark on the figures)

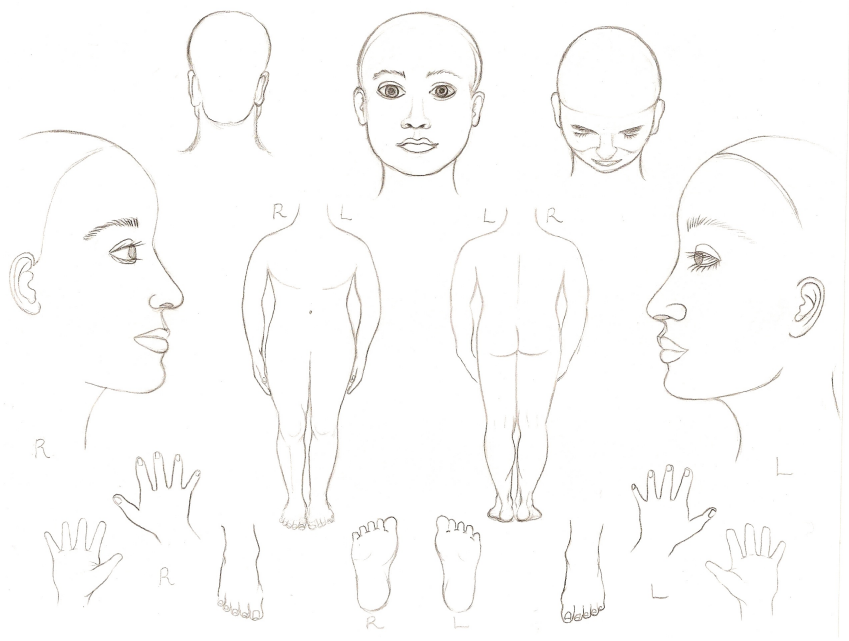
XXX = Ache

0 0 0 = numb / tingling

> > > = shooting

/ / / = stiff

*** * * = Sharp / Stabbing**



Do you have any of the following?

- ☐ Generalized muscle pain or stiffness
- ☐ Swollen, painful, stiff joints
- ☐ Bone pain
- ☐ Tremors, twitches
- ☐ Scoliosis
- ☐ Numbness or tingling
- ☐ Loss of strength
- ☐ Hernia
- ☐ Breast Implants
- ☐ Postural Issues
- ☐ History of tendonitis
- ☐ History of sprain / strain
- ☐ History of broken bones
- ☐ Other: _____

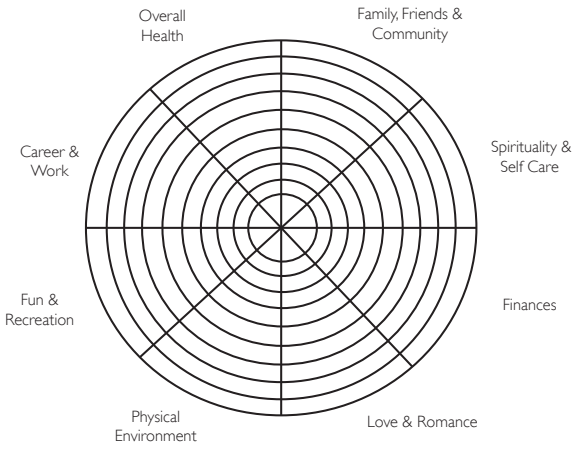
LIFE BALANCE / WELL BEING

What brings you significant joy / happiness? _____ _____
What do you love to do? _____ _____
What are your sources of stress? _____ _____
What are your mental / emotional stimulants? _____ _____
What physical activities do you enjoy? _____ _____
How do you connect with the community? _____ _____
Briefly describe your spiritual life? _____

The following wheel helps create a visualization of your happiness with specific areas of your life. There are ten levels for each area.

The center point equals zero satisfaction, radiating outward to most satisfaction at level ten

Please shade in your level of satisfaction in each area as it relates to you.
(for example, 60% satisfaction with your career would have six levels shaded)



SIGNATURE

I confirm that all of the above information is true and accurate.

_____ ____/ ____/ _____
Signature Date

_____
Printed Name

I confirm that I am the <u>legal guardian</u> of the patient and all of the information above is true and accurate

_____ ____/ ____/ _____
Signature of Guardian (if applicable) Date

_____
Printed Name of Guardian (if applicable)

Thank you for your time and determination with this paperwork. I look forward to helping you achieve your goals.

In Health,
Dr. Hilary Costello