Natural Choice Family Wellness

1300 S. Main St. Suite A, Snowflake, AZ 85937 (928)536-5525
(928)536-3010

Confidential Patient Data

If you need any assistance completing this form, please ask.

PATIENT INFORMATION Today's Date: ______________

Name: ____ Date of Birth: ______________

Address: ________________________________ City:_____________ State:_______ Zip:__________

Home Phone: ______________________Work: ____________________ Cell: ___________________

Gender: M/F Marital Status: __________________ Email Address________________________

Name of Spouse or Nearest Relative: _____________________________ Phone: _________________

How did you hear about our office: ____

Payment for Services will be by: Cash ______ Check______ Credit Card______

Are you covered by insurance: Yes____ No _____ SSN__________________ (For Ins. Purpose Only)

MEDICAL/FAMILY HISTORY S=Self M=Mother F=Father

S	M	F		S	M	F		S	M	F	
___	___	___	allergies	___	___	___	dislocations	___	___	___	neck pain
___	___	___	anemia	___	___	___	epilepsy	___	___	___	nervousness
___	___	___	arthritis	___	___	___	German measles	___	___	___	numbness
___	___	___	asthma	___	___	___	headaches	___	___	___	polio
___	___	___	back pain	___	___	___	heart trouble	___	___	___	poor circulation
___	___	___	bladder trouble	___	___	___	hepatitis	___	___	___	reproductive abn.
___	___	___	bone fracture	___	___	___	high blood press.	___	___	___	rheumatic fever
___	___	___	cancer	___	___	___	HIV/AIDS	___	___	___	rheumatism
___	___	___	chest pain	___	___	___	kidney disorders	___	___	___	scarlet fever
___	___	___	concussion	___	___	___	bowel control loss	___	___	___	serious injury
___	___	___	convulsions	___	___	___	menstrual cramps	___	___	___	sinus trouble
___	___	___	diabetes	___	___	___	multiple sclerosis	___	___	___	tuberculosis
___	___	___	indigestion	___	___	___	muscle dystrophy	___	___	___	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes ____ No ____

Describe condition: ____ Date of last physical exam: ________

Who is you Primary Care Physician: ________________________________ Clinic: ______________________

Surgical History

1) ____ Date: ____________

2) ____ Date: ____________

3) ____ Date: ____________

(Over Please)

Accident History

____Job ____Auto _____ Other 1) ____ Date: __________

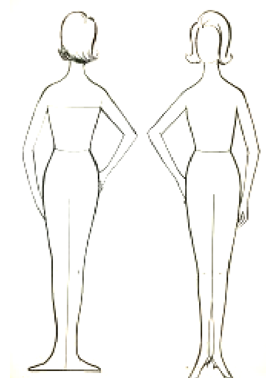
____Job ____Auto _____ Other 2) ____ Date: __________

____Job ____Auto _____ Other 3) ____ Date: __________

Have you ever had a metal implant? Yes ___ No ___ Ever been gun shot? Yes ___ No ___

Describe Major Complaints

Rate your symptoms 1-10, with 10 being the worst pain you could imagine.



1) ____ _____

2) ____ ____

3) ____ ____

4) ____ ____

Symptoms are worse in: Morning ____ Afternoon ____ Night ____
When and what was the cause?
____

____

Symptoms developed from: Job Related ____ Auto Accident ____ Accident ____ Illness ____
Unknown cause ____ Gradual onset ____ Other ____ Date Occurred: ____________
Symptoms have persisted for #: Hours ____ Day(s) ____ Week(s) ____ Month(s) ____ Years(s) ____
Symptoms: Come and go ____ Are Constant ____
Have you ever had this before? No ____ Yes ____ If yes, when? _______________________________
If you were to guess, what do you think is causing your complaints? _______________________________
Name and location of Doctors previously seen for present condition(s)?_____________________________

____

Are you allergic to any medications? Yes ____ No ____ What kind? __________________________
Are you taking any medications? Yes ____ No____ What kind? __________________________________
Are you pregnant? Yes ____ No____ Date of last menstrual period: ________________________________

Please check the following activities that aggravate your condition:

Bending ____ Reaching ____ Straining at stool ____ Coughing ____ Turning Head ____
Lifting ____ Sneezing ____Walking ____ Lying Down ____ Standing ____ Sitting ____

Please check the following activities that relieve your condition:
Bending ____ Sitting ____ Lifting ____ Standing ____ Lying Down ____ Reaching ____
Walking ____ Turning Head ____

Please check any additional symptoms you may be experiencing:

____Blurred vision ____Diarrhea ____Insomnia ____Pins/Needles
____Buzzing in ears ____Dizziness ____Light sensitive ____Low resistance to colds
____Cold feet/hands ____Face Flushed ____Loss of balance ____Shortness of breath
____Cold sweats ____Fainting ____Loss of taste ____Concentration loss/confusion
____Stiff neck ____Fatigue ____Muscle jerking ____Indigestion
____Headaches ____Fever ____Constipation ____Head seems too heavy
____Numbness in fingers ____Numbness in toe ____Ringing in ears ____Depression/weeping spells

Patient Signature: ____ **Date:** ____________________