New Patient Application and Case History (Please Print Neatly)

Name____ Sex: M / F Date of Birth______________ Today's Date_________

Address__________________________ City__________________________ State___________ Zip_______________

Primary Phone_____________________ Alternate Phone_____________________ Cell Phone_________________

e-mail: ____ Height__________ Age______

How Did You Hear About Us? ____

Driver's License #____ State_____

Marital Status: S/M/D/W/Sep Spouse name___________ Children/ages__________________________________

Present Complaints

1. Main Problem(s):____

____

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2. Symptoms: List in order of severity

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3. What are the 3 things your condition(s) have caused you to miss most:

____

____

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4. What relieves your symptoms or causes them to return:

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5. Describe the first time you had symptoms:

____

____

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6. If your symptoms include pain:

What is the quality (sharp, dull, achy, burning, color, etc.)____

Does the pain radiate: Y / N Where: ____

7. Do your symptoms occur at a specific time, place, or environment: Y / N Where: _______________________

When and for how long do symptoms last in each episode: ____

____

8. How often are you aware of your main problem (circle one)

Occasionally (25% of the time) Frequently (75% of the time)

Intermittently (50% of the time) Constantly (100% of the time)

9. What types of treatment have you received:

Prescription/Drug therapy____

Nutritional ____

____

Alternative/Holistic____

10. List your health goals in order of importance:

____

____

____

Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10 (1= not much, 10 highly motivated)

11. What are you hoping happens as a result of your treatment?

____

____

12. If you don't do something about your problem what do you think will happen in 6 months,12 months, 5 years?

____

____

13. Due to your condition have you lost time from (describe how much time and what tasks have been limited)?

Work: Y / N Describe: ____

Family: Y / N Describe: ____

Leisure Activities Y / N Describe: ____

Other: Y / N Describe: ____

14. When was the last time you really felt well? ____

15. What is it you cannot do that you would like to be doing because of how you feel? _______________________

____

16. Have you had any metal fillings, root canals or other dental work? __________________________________

17. Do you believe in the healing power of prayer?   Y / N   Not Sure

18. Do you have any household pets that you are in close contact with? ___________________________________

19. If yes to #18, do they sleep in bed with you? ____

Blood sugar

HIGHEST your blood sugar gets WITHOUT medication____   HIGHEST your blood sugar gets WITH medication____

LOWEST your blood sugar gets WITHOUT medication_____   LOWEST your blood sugar gets WITH medication____

Medications

(List all prescription, over the counter, botanicals, supplements, homeopathic, vitamins, minerals)

____   ____

____   ____

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Medical and Social History

Surgeries/Hospitalizations	Date	Trauma	Date

Family History: mother, father, siblings, children

	Diabetes	Heart	Kidney	Cancer	Back
Mother	( )	( )	( )	( )	( )
Father	( )	( )	( )	( )	( )
Brother(s)	( )	( )	( )	( )	( )
Sister(s)	( )	( )	( )	( )	( )
Children	( )	( )	( )	( )	( )

Exercise (circle) NONE   LIGHT   MODERATE   STRENUOUS

What type: ___________________________________

How often: DAILY   WEEKLY   OCCASIONALLY

Do you use: Alcohol   Y   N   Tobacco   Y   N   Caffeine Y   N

____drinks/day/week   ___pack/day   ____cups/day

Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced)

CONSTITUTIONAL

- P C Fatigue
- P C Recent weight change
- P C Fever

EYES

- P C Blurred/double vision
- P C Glasses/contacts
- P C Eye disease or injury

EAR/NOSE/MOUTH/THROAT

- P C Swollen glands in neck
- P C Hearing loss or ringing
- P C Earaches or drainage
- P C Chronic sinus problems or rhinitis
- P C Nose bleeds
- P C Mouth sores / Bleeding gums
- P C Bad breath / bad taste
- P C Sore throat or voice change

CARDIOVASCULAR

- P C High or Low Blood Pressure
- P C Shortness of breath walking/lying
- P C Heart disease
- P C Chest pain or angina pectoris
- P C Palpatation
- P C Mitral Valve Prolapse
- P C Feet or ankle swelling
- P C Shortness of breath
- P C Spitting up blood

PSYCHIATRIC

- P C Insomnia
- P C Memory loss or confusion
- P C Nervousness
- P C Depression

GENITOURINARY

- P C Frequent urination
- P C Burning or painful urination
- P C Blood in urine
- P C Change in force or strain urinating
- P C Kidney stones
- P C Sexual difficulty
- P C Male : testicle pain
- P C Female: pain / irregular periods
- P C Female: pregnant
- P C Bladder Infections
- P C Kidney Disease
- P C Hemorrhoids

GASTROINTESTINAL

- P C Abdominal pain
- P C Nausea or Vomiting
- P C Rectal bleeding/blood in stool
- P C Painful BM / constipation
- P C Ulcer
- P C Change in bowel movement
- P C Frequent diarrhea
- P C Loss of appetite

RESPIRATORY

- P C Chronic or frequent cough
- P C Spitting up blood
- P C Pneumonia / Bronchitis
- P C Shortness of breath
- P C Wheezing
- P C Asthma

ENDOCRINE

- P C Glandular or hormone problem
- P C Excessive thirst or urination
- P C Heat or cold intolerance
- P C Skin becoming dryer
- P C Change in hat or glove size
- P C Diabetes
- P C Thyroid Disease

MUSCUOSKELETAL

- P C Back pain
- P C Joint pain
- P C Joint stiffness and swelling
- P C Muscle pain or cramps
- P C Muscle or joint weakness
- P C Difficulty walking
- P C Cold extremities

INTEGUMENTARY (skin, breast)

- P C Change in skin color
- P C Change in Hair or Nails
- P C Varicose veins
- P C Breast pain / discharge
- P C Breast lump
- P C Hives or Eczema
- P C Rash or itching

NEUROLOG ICAL

- P C Freq./ recurring headaches
- P C Migraine headache
- P C Convulsions or seizures
- P C Numbness or tingling
- P C Tremors
- P C Paralysis
- P C Head injury
- P C Light headed or dizzy
- P C Stroke

HEMATOLOGIC/LYMPHATIC/OTHER

- P C Slow to heal after cuts
- P C Easy bleeding or bruising
- P C Anemia
- P C Phlebitis
- P C Past transfusion
- P C Enlarged glands
- P C Blood or Plasma Transfusions
- P C Hepatitis
- P C Cancer
- P C Infectious Mono
- P C AIDS or HIV+
- P C Venereal
- P C Chicken pox

ALLERGIES / OTHER (drugs, food, or environmental) ____________________

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____

RECENT TESTS (lab work, x-rays, CT, MRI) ____________________

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____

OTHER PROVIDERS

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Doctor's Notes

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FEES

Physician's fees are based on the length of time that Dr. Podlaski spends with you and the complexity of your problem(s). Most initial evaluations will take an hour and a half to two hours. Additional lab tests, such as Comprehensive Blood Chemistry Profile, Urinalysis, Hair Analysis, Food Allergy Testing, Functional Medicine Testing that may be required are in addition to the physician's initial examination fee.

The length of time for regular follow up office visits are normally scheduled to accommodate individual patient needs as determined by the nature of each patient's health challenges and the doctor's estimation of the time necessary to appropriately address each patient's individual health concerns. At the Natural Medicine Institute we never want a patient to feel rushed or leave the office without having their questions or concerns fully satisfied. We endeavor to answer all questions as quickly as possible in the time scheduled.

We require payment in full at the time a person receives our services. We accept most major credit cards, personal checks or cash. We do not accept any insurance as payment for any of our services and we will not submit insurance paperwork on your behalf including Medicare or other insurance carriers.

Please understand that insurance companies and Medicare will not cover nutritional therapies, functional medicine testing or similar services that they consider maintenance, preventative or screening in nature

I clearly understand and agree of my own free will that all services rendered to me are to be charged directly to me and that I am personally responsible for payments at the time professional services are rendered to me. Additionally, I understand and agree that no insurance will be filed for me and that I will not file for insurance or Medicare re-imbursement for any of the services rendered to me.

Patient's Printed Name: ____

Patient's Signature____ **Date**______

Guardian or Spouse's Signature ______________________________**Date**______