Dr Deborah Maken

natureneuro therapeutics

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Patient Information

Name	DOB	Gender M F
	Email	
Address	Home Phone	
	Mobile Phone	

Emergency Contact

Name Relationship to you Phone

Have you seen a doctor that practices natural or integrative medicine before? Y/N
If so, what type of natural medicine oriented clinicians have you visited?

___Naturopathic Doctor ___Holistic MD/DO ___Acupuncturist ___Chiropractor ___Other:

How did you find us?
___Doctor Referral ___Patient Referral ___web search ___YouTube Video

If you were referred, please let us know by whom:

Do you have questions about Naturopathic Medicine?

What are your health goals?

Do you have health insurance? Y/N
If Yes, HMO or PPO? Who is your insurance carrier?

Please list other health care providers you are currently working with:

Name	Specialty	Contact Info
1.		
2.		
3.		
4.		

Current Health Concerns

Please list by order of importance to you. (Attach another list if necessary)	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe:
1.		
2.		
3.		
4.		
5.		
6.		

Personal & Family Health History

Date of last physical exam?	Date of last Dexa Scan (bone density scan)?
Date of most recent blood work?	Date of last colonoscopy?
Mother: ❑ Living ❑ Deceased Age: Cause if deceased:	Sibling: Y/N Number living: Number deceased: Gender: Age(s): Cause(s) if deceased: 1.
Father: ❑ Living ❑ Deceased Age: Cause if deceased:	2. 3. 4.

Personal & Family Diagnosed Health Conditions	YES	Who? Indicate self or a specific family member	Notes:
ADD/ADHD	❑		
Alcohol/drug addiction	❑		
Anemia	❑		
Alzheimer's/Dementia	❑		
Arthritis (Osteo or Rheumatoid?)	❑		
Asthma	❑		
Autoimmune diseases	❑		
Birth defects	❑		
Blood disorder	❑		
Cancer	❑		What kind? Age diagnosed?
Cardiovascular Disease	❑		
Depression	❑		
Diabetes Type 2	❑		
Diverticulosis	❑		
Eating Disorder	❑		
Eczema	❑		
Epilepsy/Seizure Disorder	❑		
Fibromyalgia	❑		
Gallstones/Gall Bladder Disease	❑		
Gout	❑		
High Cholesterol	❑		
HIV/Aids	❑		
Hypertension	❑		
Inflammatory Bowel Disease	❑		
Kidney Disease	❑		
Learning Disability	❑		
Liver Disease - If Y, specify:	❑		
Mental illness – If Y, specify:	❑		
Neurologic disorder	❑		
Osteopenia/Osteoporosis	❑		
Stomach or Duodenal Ulcers	❑		
Stroke	❑		
Thyroid disease	❑		
Other:	❑		

Review Of Systems – Check/Circle appropriate responses below

Neuro-Endocrine:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
"Brain Fog"/ Memory difficulty	❑	❑	1 2 3	
Depression	❑	❑	1 2 3	
Irritability	❑	❑	1 2 3	
Anxiety	❑	❑	1 2 3	
Panic Attacks	❑	❑	1 2 3	
Poor stamina	❑	❑	1 2 3	
Fatigue	❑	❑	1 2 3	Recent onset or Chronic?
Sensitive to light	❑	❑	1 2 3	
Sensitive to smells	❑	❑	1 2 3	
Vertigo/dizziness	❑	❑	1 2 3	
Fainting	❑	❑	1 2 3	
Seizures	❑	❑	1 2 3	
Thirst ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Appetite ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Hypoglycemia - need to eat often or feel weak, irritable shaky	❑	❑	1 2 3	
Weight ❑ Gain ❑ Loss	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	How much did you weigh last yr? 5 years ago? 10 years ago? What is your ideal weight?
Energy				Rate from 1-10 Best time of day? Hardest time of day? Consistent all day?
Sweat ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	

Body Temp ❑ Cold ❑ Hot	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Head:	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
Hair	❑	❑		❑ Dry ❑ Thinning ❑ Excessive shedding ❑ Balding - Where? ❑Alopecia ❑Male Pattern ❑Other:
Headaches	❑	❑	1 2 3	Location of pain? Sensation of pain?
Migraines	❑	❑	1 2 3	
Eyes:				
Dryness	❑	❑	1 2 3	
Tearing	❑	❑	1 2 3	
Cataract (s)	❑	❑	1 2 3	
Glaucoma	❑	❑	1 2 3	
Vision	❑	❑		❑ Near sighted ❑ Far sighted Change in vision?
Under eye bags /dark circles	❑	❑	1 2 3	
Ears:				
Ear infections	❑	❑	1 2 3	
Excessive ear wax build-up	❑	❑	1 2 3	
Tinnitus	❑	❑	1 2 3	
Nose:				
Nasal congestion	❑	❑	1 2 3	
Nasal dryness	❑	❑	1 2 3	
Nose runs	❑	❑	1 2 3	
Nose bleeds	❑	❑	1 2 3	
Post-nasal drip	❑	❑	1 2 3	
Sinus pressure	❑	❑	1 2 3	
Sinus infections	❑	❑	1 2 3	

Mouth/Throat:				
Canker sores/ Oral lesions	❑	❑	1 2 3	
Periodontal disease	❑	❑	1 2 3	
Amalgam fillings	❑	❑	1 2 3	How many?
Hoarse voice	❑	❑	1 2 3	
Cardiovascular:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Shortness of breath	❑	❑	1 2 3	
High blood pressure	❑	❑	1 2 3	
Low blood pressure	❑	❑	1 2 3	
Chest pain	❑	❑	1 2 3	
Palpitations/ ”flutters”	❑	❑	1 2 3	
Heart rhythm abnormalities	❑	❑	1 2 3	
Murmur	❑	❑	1 2 3	
Poor circulation: cold hands/feet	❑	❑	1 2 3	
Varicose veins	❑	❑	1 2 3	
Leg cramps	❑	❑	1 2 3	
Loss of hair on lower limbs	❑	❑	1 2 3	
Respiratory:				
Cough	❑	❑	1 2 3	
Wheezing	❑	❑	1 2 3	
Bronchitis	❑	❑	1 2 3	
Pneumonia	❑	❑	1 2 3	
Positive TB test	❑	❑	1 2 3	
Immune system:				
Frequent colds/flus	❑	❑	1 2 3	
Long recovery time from illness	❑	❑	1 2 3	
Frequent antibiotic use	❑	❑	1 2 3	
Chronic inflammation	❑	❑	1 2 3	
Chronic viral infections (EBV, CMV, HIV)	❑	❑		
Swollen glands	❑	❑	1 2 3	

Night sweats	❑	❑	1 2 3	
Gastro-Intestinal:				
Acid reflux/ heartburn	❑	❑	1 2 3	
Abdominal pain	❑	❑	1 2 3	

Gastro-Intestinal: ***continued***	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
Ulcer(s)	❑	❑	1 2 3	
Intestinal cramping	❑	❑	1 2 3	
Abdominal bloating	❑	❑	1 2 3	
Belching	❑	❑	1 2 3	
Nausea	❑	❑	1 2 3	
Vomiting	❑	❑	1 2 3	
Bowel Movements Constipation Diarrhea Blood or mucus	 ❑ ❑ ❑	 ❑ ❑ ❑	 1 2 3 1 2 3 1 2 3	Frequency: ❑ Multiple BMs daily ❑ 1x per day ❑ Every other day ❑ Other: Consistency: ❑Loose ❑Soft ❑ Formed ❑Hard ❑Pellets ❑ Other:
Flatulence	❑	❑	1 2 3	
Itching anus	❑	❑	1 2 3	
Rectal pain/ bleeding	❑	❑	1 2 3	
Hemorrhoids	❑	❑	1 2 3	
Fissures	❑	❑	1 2 3	
Genito-Urinary:				
Frequent urination	❑	❑	1 2 3	❑ Day ❑ Night
Urinary incontinence	❑	❑	1 2 3	❑ Day ❑ Night
Blood in urine	❑	❑	1 2 3	How long?
Urinary tract infections	❑	❑	1 2 3	
Change in libido	❑	❑	1 2 3	❑ Increased ❑ Decreased
Sexually active	❑	❑		If Y, frequency of sexual activity? Number of partners in the last year? Satisfied with your sex life? Y/N
Sexually transmitted infections	❑	❑		❑ HIV ❑ Herpes ❑ HPV/Warts ❑ Gonorrhea ❑ Chlamydia ❑ Syphilis ❑ Hepatitis
Birth control/ barrier method used?	❑	❑		If yes, what type(s)

Impaired fertility? Y/N	❑	❑		
Musculoskeletal:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Joint Pain	❑	❑	1 2 3	Where?
Muscle Weakness Pain	❑ ❑	❑ ❑	1 2 3	
Skin:				Quality: Dry Oily Normal Thin
Bruise easily	❑	❑	1 2 3	
Hives	❑	❑	1 2 3	
Rashes	❑	❑	1 2 3	
Frequent fungal infections	❑	❑	1 2 3	
Bumpy skin	❑	❑	1 2 3	
Flaky scalp	❑	❑	1 2 3	
Psoriasis	❑	❑	1 2 3	
Eczema	❑	❑	1 2 3	
Acne	❑	❑	1 2 3	
Precancerous/ cancerous growths	❑	❑	1 2 3	
Moles	❑	❑	1 2 3	
Warts	❑	❑	1 2 3	
Female Health:				
Vaginal symptoms: Itchiness Discharge Odor Dryness Painful intercourse Lacerations/tears Yeast infections Bacterial vaginosis	 ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑	 ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑	 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3	Date of last gynecologic exam: Ever had an abnormal pap? Y/N If yes, when?
Irregular bleeding	❑	❑	1 2 3	
Menstrual cramps	❑	❑	1 2 3	
Mood volatility Irritability Weepiness	❑ ❑ ❑	❑ ❑ ❑	1 2 3 1 2 3 1 2 3	

Breast tenderness Lumps/Cysts	❑ ❑	❑ ❑	1 2 3	
Back aches	❑	❑	1 2 3	
Water retention	❑	❑	1 2 3	
Abdominal bloating	❑	❑	1 2 3	
Sugar cravings	❑	❑	1 2 3	
Female Health: ***continued***	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
Endometriosis	❑	❑	1 2 3	
Uterine fibroids	❑	❑	1 2 3	
Ovarian cysts	❑	❑	1 2 3	
Hot flashes/sweats	❑	❑	1 2 3	Day Night

Reproductive history: Number of pregnancies: Number of miscarriages: Number of abortions: Number of births: Date of last birth:	Date of last menstrual period: *Cycle length* regular? Y/N ❑ Short ❑ Long ❑ Irregular *Blood flow:* how many days? ❑ Light ❑ Medium ❑ Heavy ❑ Large clots
Oral contraceptives, HRT/BHRT or other hormone treatment/ replacement used? Y/N	If so what has been used and how long?

Past Medical History

Please list any hospitalizations and any major past illnesses or injuries (eg, broken bones, surgeries, etc):

Prescribed medications and over the counter medications – attach a separate list if necessary

Medication Name	Dose	When started?	Why?
1.			
2.			
3.			

4.			
5.			

Drug Allergies?

Any known medication allergies? Y/N

If Yes, which medications:

What allergic reaction symptoms do you experience?

Supplements – please list all vitamins/botanicals, homeopathics, etc.

Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started	Why
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Lifestyle & Social History

Diet

Do you follow any special diet type or restrictions?	Are there foods you crave strongly?
What foods make you feel poorly? Explain:	What foods make you feel the best? Explain:

How would you describe your relationship with food?

Please list typical foods consumed daily – specify typical times of day for each:

Breakfast	
Lunch	
Dinner	
Snacks	
Sweets	
Water	How much? Tap, filtered, bottled?

Please check the appropriate box below to indicate the frequency of consumption:

	Daily	Weekly	Monthly	Occasionally (1-2x per mo)	Rarely (1-2x per yr)	Never
Sugar						
Artificial sweeteners						
Fast food						
Fried food						
Processed food						
Flour/baked goods						
Caffeine						
Soda?						
Alcohol?						

Notes/details:

Habits

Do you smoke cigarettes? Y/N	Packs per day?	Duration of habit?
	Past Use?	If so, how long ago did you quit?
Do you use recreation drugs? Y/N	If Y, what type?	
	How often?	
	Past Use?	If so, how long ago did you quit?
Have you ever been treated For drug/alcohol addiction? Y/N	If Y, describe:	How long ago?

Sleep

How many hours of sleep do you get regularly each night?		Time you go to bed?
Do you fall asleep easily? Y/N	Do you sleep soundly? Y/N	Time you get up?
Do you wake rested? Y/N	What is your AM mood like?	

Notes:

Exercise

Do you exercise regularly? Y/N	How often?	For how long?
What type of exercise(s) do you do?		

Spiritual practices

Do you have any spiritual practices you follow? Y/N	If yes, what kind?

Occupation

What is your occupation?	Do you like your work? Y/N
Number of hours worked per week:	Do you like your work environment? Y/N If no, please explain:

Stress Level

Rate 1-10 (1 = Very Low, 10 = High)	Source(s)of stress:

What do you do to cope with stress?

Sense of Well-being

Rate your sense of wellbeing from 1-10 (1 = Very Low, 10 = High)	Predominant emotional state?

What do you do to regularly support your health and well-being?

What challenges do you face with your efforts to maintain health?

Where do you feel you could use more support?

natureneuro therapeutics Financial Policy

natureneuro therapeutics is a cash-based practice that accepts cash or check payment. Payment is required on the day services are rendered. We do not file insurance claims but we will provide you with a "superbill" that contains the diagnosis and procedure codes required for insurance reimbursement. natureneuro therapeutics assumes no responsibility for services not reimbursed by your insurance company.

I have read, understand, and agree to the above policies:

_____

Please Print Your Name

_____

Signature Date