# *NorthPointe Medicine, P.C.*

## Patient Information

Name: _____ Today's Date: _____

❑ Male ❑ Female Date of Birth: _____ Age: _____ Blood Type: _____

Phone: Home# _____ Work# _____ Cell# _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address:_____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed Partner's Name: _____

Occupation: _____Employer: _____Supervisor: _____

Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Payment (if minor) _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Person: _____Relationship to Patient: _____

Phone: Home# _____ Work# _____ Cell# _____

## Agreement of Financial Responsibility

I, _____ the undersigned, agree to payment as services are rendered unless prior agreement has been made in writing by NorthPointe Medicine, P.C.

As a courtesy to you we will file to your insurance company on the plans for which NorthPointe Medicine, P.C. is a provider. This does not include workman's comp, Medicaid and Medicare.

Concerning insurance claims: I assume full financial responsibility for any fees I, or parties I am responsible for, have incurred at NorthPointe Medicine, P.C. that may not be paid by medical insurance (e.g. deductibles and copayment or coinsurance) or any other second party, as per this agreement.

***Please kindly give 24 hr advance notice if you cannot keep your appointment. Your prompt notice of cancellation allows others to be seen. If you do not show up for an appointment or fail to give 24 hr notice a $75.00 fee will be charged.***

***A* $25.00 fee will be charged for any returned checks.**

I hereby agree to the above statement of financial responsibility to NorthPointe Medicine, P.C.

Patient/Responsible Party Signature: _____Date: _____

How did you hear about our office? _____

Main problem you would like help with? _____

How long have you had this problem? _____

To what extent does this problem interfere with your daily activities? _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

If you have had any lab work done in the last 12 months please provide copies or the name of lab:

_____

What other treatments have you tried, and what has been your response? _____

_____

What kind of nutritional changes would you be willing to make for your health? _____

_____

---

**DIET - PERSONAL HABITS**

Height: Current: _____ft _____in 1 year ago: Same or _____ft _____in

Weight: Current: _____lbs 1 year ago: _____lbs

Briefly describe a typical day's meals:

Breakfast _____

Lunch _____

Dinner _____

How many servings of fruits and vegetables do you eat every day? _____

Do you diet or restrict your food intake? ❑ No ❑ Yes - if yes please explain _____

Do you have a regular exercise program? ❑ No ❑ Yes - if yes please explain _____

Do you smoke? ❑ No ❑ Yes - if yes, how much/often? _____

Do you drink alcoholic beverages ❑ No ❑ Yes - if yes, how much/often? _____

Do you drink coffee, or other caffeinated beverages? ❑ No ❑ Yes - if yes, how much/often? _____

Please list any allergies (medication, food, or environmental) you may have:

_____

_____

List any medications, vitamins, hormones, homeopathics, laxatives, herbs, or other supplements you are taking. Please include doses and how often you take them. **(Attach a separate sheet if needed)**

_____

_____

## PAST MEDICAL HISTORY

Please indicate if you have/have had any of these significant illnesses and the date of occurrence.

| | | |
|---|---|---|
| _____ Cancer | _____ Diabetes | _____ Heart Disease |
| _____ High Blood Pressure | _____ Hepatitis | _____ Respiratory Disease |
| _____ Rheumatic Fever | _____ Seizures | _____ Thyroid Disease |
| _____ Alcohol/Drug Addiction | _____ Other:_____ | |

## FAMILY MEDICAL HISTORY

Please circle and indicate which family member has had any of the following.

| | | |
|---|---|---|
| _____ Alcoholism | _____ Asthma | _____ Autoimmune Disorders |
| _____ Cancer (type _____) | | _____ Diabetes |
| _____ Heart Disease | _____ Seizures | _____ Stroke |

**Please check if you have experienced any of the following in the last 3 months**

## GENERAL

| | | |
|---|---|---|
| _____ Head or chest cold | _____ Localized Weakness | _____ Sudden Energy Drop |
| _____ Flu | _____ Fevers or chills | _____ Sweat easily |
| _____ Easy to bleed or bruise | _____ Peculiar tastes or smells | _____ Fatigue easily |
| _____ Strong Thirst | _____ Poor sleeping | _____ Always fatigued |
| _____ Tremor | _____ Poor balance | _____ Weight loss |
| _____ Night sweats | _____ Cravings | _____ Weight gain |
| _____ No thirst | _____ Puffiness or swelling | _____ Other |

## SKIN AND HAIR

| | | |
|---|---|---|
| _____ Rashes | _____ Itching | _____ Dandruff |
| _____ Skin ulcers | _____ Eczema | _____ Hair loss |
| _____ Hives | _____ Pimples | _____ Recent moles |

## HEAD, EYES, NOSE AND THROAT

| | | |
|---|---|---|
| _____ Glasses | _____ Dizziness | _____ Sinus Problems |
| _____ Poor Vision | _____ Ear Ringing | _____ Nose Bleeds |
| _____ Cataracts | _____ Poor hearing/hearing loss | _____ Teeth grinding |
| _____ Eye Strain | _____ Ear aches | _____ Teeth problems |
| _____ Night blindness | _____ Headaches | _____ Gum problems |
| _____ Blurry vision | _____ Concussions | _____ Recurrent sore throat |
| _____ Eye pain | _____ Facial pain | _____ Lip/tongue sores |
| _____ Color blindness | _____ Jaw click | _____ Sore throat |
| _____ Spots in front of eyes | _____ Migraines | _____ Other |
| _____ Dental Amalgam Fillings | _____ Root Canals | |

## CARDIOVASCULAR

| | | |
|---|---|---|
| _____ High blood pressure | _____ Low blood pressure | _____ Heart murmur |
| _____ Cold hands or feet | _____ Blood clots | _____ Irregular heartbeat |
| _____ Swelling of hands | _____ Phlebitis | _____ Palpitations |
| _____ Swelling of feet | _____ Fainting | _____ Light headedness |
| _____ Angina/chest pain | _____ Varicose veins | _____ High cholesterol |

## RESPIRATORY

| | | | | | |
|---|---|---|---|---|---|
| _____ | Dry cough | _____ | Bronchitis | _____ | Difficulty breathing |
| _____ | Cough/Phlegm | _____ | Coughing up blood | _____ | Pneumonia |
| _____ | Shortness of breath | _____ | Painful breathing | _____ | Emphysema |
| _____ | Asthma | _____ | Wheezing | _____ | Other |
| _____ | Asthma, worse on exertion | | | | |

## GASTROINTESTINAL

| | | | | | |
|---|---|---|---|---|---|
| _____ | Nausea | _____ | Constipation | _____ | Diarrhea |
| _____ | Bad breath | _____ | Black Stools | _____ | Abdominal pain |
| _____ | Vomiting | _____ | Chronic laxative use | _____ | Intestinal gas |
| _____ | Indigestion | _____ | Blood in stools | _____ | Belching |
| _____ | Decreased appetite | _____ | Rectal pain | _____ | Jaundice |
| _____ | Excessive appetite | _____ | Hemorrhoids | | |
| _____ | Other changes in appetite | | | _____ | Other _____ |

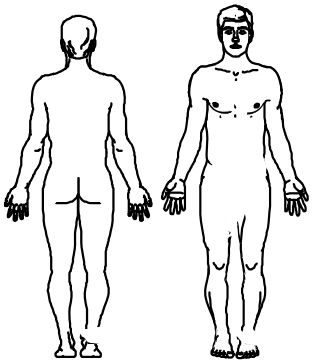
## GENITOURINARY

| | | | | | |
|---|---|---|---|---|---|
| _____ | Difficult urination | _____ | Urgency to urinate | _____ | Blood in urine |
| _____ | Painful urination | _____ | Frequent urination | _____ | Herpes |
| _____ | Decrease in urine flow | _____ | Kidney stones | _____ | Low sexual energy |
| _____ | Cloudy urine | _____ | Frequent night urination | _____ | Excess sexual energy |
| _____ | Genital sores | _____ | Unable to hold urine | _____ | Other _____ |

## MUSCULOSKELETAL PAIN OR DISCOMFORT – PLEASE INDICATE LOCATION ON DIAGRAM TO THE RIGHT

The following best describes the nature of these pains. . . .

| | | | | | |
|---|---|---|---|---|---|
| —— | Sharp | —— | Empty | —— | Worse when humid |
| —— | Dull | —— | Tight | —— | Worse when dry |
| —— | Throbbing | —— | Heavy | —— | Worse when hot |
| —— | Distending | —— | Moving | —— | Worse when cold |
| —— | Cramping | —— | Worse at night | —— | Aggravated by diet |
| —— | Burning | —— | Worse during the day | —— | Worse with stress |
| | | | | —— | Other _____ |



**Please mark areas of pain**

If the pain is due to an injury, or you know the cause of the pain, please explain. _____

_____

Is there anything that makes you feel better? _____

Please list your past surgeries or major injuries and their dates: _____

_____

## GYNECOLOGY – PREGNANCY

| | | | | | |
|---|---|---|---|---|---|
| _____ | Irregular period | _____ | Painful periods | _____ | Vaginal discharge |
| _____ | Vaginal sores | _____ | Clots | _____ | Premature births |
| _____ | Abortions | _____ | Miscarriages | _____ | PMS |
| _____ | Heavy flow | _____ | Light flow | _____ | Spotting |

Age at 1st menses _____ Number of live births _____

Date of last menses _____ Complications? _____

Duration of menses (days) _____ Current birth control method _____

Number of days from 1st day of menses to 1st day next menses _____

## NEURO-PSYCHOLOGICAL

| | | | | | |
|---|---|---|---|---|---|
| _____ | Seizures | _____ | Numb body areas | _____ | Concussion |
| _____ | Twitches | _____ | Lack of coordination | _____ | Depression |
| _____ | Bad temper | _____ | Loss of balance | _____ | Stress |
| _____ | Poor memory | _____ | Anxiety | _____ | Mood swings |
| _____ | Irritability | _____ | Tremors | _____ | Other _____ |

Have you ever been emotionally, physically or sexually abused? _____

Have you recently had unusually stressful experiences, such as; divorce, death of a loved one, birth, marriage, bankruptcy, job loss, illness, injury)? _____

Is there constant stress in your life? _____

Do you use any recreational drugs? ❑ No ❑ Yes - if yes, how much/often? _____

Is there anything else you would like to discuss or comment about? _____

_____

_____

**Have you ever had any of the following? If yes, please explain.**

Vaccinations_____ Frequent Tylenol use_____

Antibiotics_____ Blood transfusions_____

Aspartame intake – (Equal, diet soda)_____ High fish intake (large, predatory)_____

Heavy metal exposure_____ Chemical exposure_____

Pesticide exposure in home_____ Tick bite history (rash, joint pain)_____

Well water consumption _____ Travel history_____

Pets with infections, illness_____ Mold exposure in home or workplace_____

Electrical overexposure – high tension wire, _____

work place, etc_____