

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.

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.

<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Alcohol/Drug Addiction	<input type="checkbox"/> Other: _____	

FAMILY MEDICAL HISTORY

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

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autoimmune Disorders
<input type="checkbox"/> Cancer (type _____)	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke

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

GENERAL

<input type="checkbox"/> Head or chest cold	<input type="checkbox"/> Localized Weakness	<input type="checkbox"/> Sudden Energy Drop
<input type="checkbox"/> Flu	<input type="checkbox"/> Fevers or chills	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Easy to bleed or bruise	<input type="checkbox"/> Peculiar tastes or smells	<input type="checkbox"/> Fatigue easily
<input type="checkbox"/> Strong Thirst	<input type="checkbox"/> Poor sleeping	<input type="checkbox"/> Always fatigued
<input type="checkbox"/> Tremor	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Cravings	<input type="checkbox"/> Weight gain
<input type="checkbox"/> No thirst	<input type="checkbox"/> Puffiness or swelling	<input type="checkbox"/> Other

SKIN AND HAIR

<input type="checkbox"/> Rashes	<input type="checkbox"/> Itching	<input type="checkbox"/> Dandruff
<input type="checkbox"/> Skin ulcers	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hair loss
<input type="checkbox"/> Hives	<input type="checkbox"/> Pimples	<input type="checkbox"/> Recent moles

HEAD, EYES, NOSE AND THROAT

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

CARDIOVASCULAR

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Swelling of feet	<input type="checkbox"/> Fainting	<input type="checkbox"/> Light headedness
<input type="checkbox"/> Angina/chest pain	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> High cholesterol

RESPIRATORY

- | | | |
|----------------------------------------------------|--------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Dry cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Cough/Phlegm | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Painful breathing | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asthma, worse on exertion | | |

GASTROINTESTINAL

- | | | |
|----------------------------------------------------|-----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other changes in appetite | | |

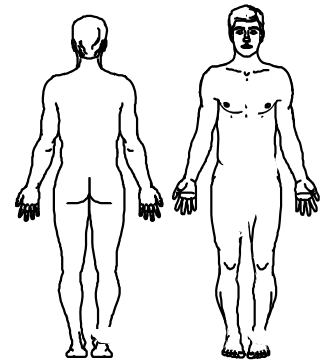
GENITOURINARY

- | | | |
|-------------------------------------------------|---------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Decrease in urine flow | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Low sexual energy |
| <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Frequent night urination | <input type="checkbox"/> Excess sexual energy |
| <input type="checkbox"/> Genital sores | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Other _____ |

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

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

- | | | |
|-------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Empty | <input type="checkbox"/> Worse when humid |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tight | <input type="checkbox"/> Worse when dry |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Heavy | <input type="checkbox"/> Worse when hot |
| <input type="checkbox"/> Distending | <input type="checkbox"/> Moving | <input type="checkbox"/> Worse when cold |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Worse at night | <input type="checkbox"/> Aggravated by diet |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Worse during the day | <input type="checkbox"/> Worse with stress |
| | | <input type="checkbox"/> 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 1 st menses _____	Number of live births _____
Date of last menses _____	Complications? _____
Duration of menses (days) _____	Current birth control method _____
Number of days from 1 st day of menses to 1 st 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 _____	_____