

NEW YORK NATURAL MEDICINE

PARK SLOPE
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TODAY'S DATE: ___/___/___

PATIENT CONTACT INFORMATION

NAME: _____ DATE OF BIRTH: ___/___/___

STREET ADDRESS: _____ CITY: _____ STATE: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL: _____

WHICH NUMBER SHOULD I USE TO LEAVE
CONFIDENTIAL MESSAGES? [CIRCLE]

HOME WORK CELL

OR DON'T LEAVE CONFIDENTIAL MESSAGES,

PLEASE SPEAK DIRECTLY TO ME

WOULD YOU LIKE TO RECEIVE A MONTHLY EMAIL NEWSLETTER? YES / NO

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE: _____

RELATION: _____

NAME: _____ PHONE: _____

RELATION: _____

HEALTH CARE PRACTITIONER INFORMATION

PRIMARY CARE PHYSICIAN [PCP]: _____

CLINIC / OFFICE NAME: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____

PHONE NUMBER: _____ FAX NUMBER: _____

SPECIALIST #1: _____

CLINIC / OFFICE NAME: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____

PHONE NUMBER: _____ FAX NUMBER: _____

SPECIALIST #2: _____

CLINIC / OFFICE NAME: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____

PHONE NUMBER: _____ FAX NUMBER: _____

HEALTH CONDITIONS OR GOALS

CONDITION OR GOALS	DURATION OF THE CONDITION	SEVERITY OR DAILY IMPACT	CURRENTLY BEING TREATED?	TREATMENT PROVIDED BY

PLEASE LIST ANY KNOWN DRUG ALLERGIES: _____

DO YOU HAVE ANY FOOD ALLERGIES? HOSPITALIZED DUE TO ALLERGIC REACTION? _____

DO YOU HAVE ANY FOOD SENSITIVITIES? _____

DO YOU FOLLOW ANY PARTICULAR DIETARY HABITS / BELIEFS? _____

FAMILY MEDICAL HISTORY

HAVE ANY OF YOUR FAMILY MEMBERS HAD SIMILAR CONDITIONS? YES / NO
PLEASE LIST: _____

PLEASE LIST ANY MAJOR ILLNESSES THAT YOUR FAMILY MEMBERS EXPERIENCED: _____

CURRENT MEDICATIONS

MEDICATION [+ DOSAGE]	REASON IT WAS PRESCRIBED	WHEN DID YOU START TAKING IT	EFFECTIVE AT ADDRESSING YOUR CONCERN? Y/N

CURRENT SUPPLEMENTS

SUPPLEMENTS, VITAMINS, MINERALS, HERBS, ETC. [+ DOSAGE]	REASON IT WAS PRESCRIBED	WHEN DID YOU START TAKING IT	EFFECTIVE AT ADDRESSING YOUR CONCERN? Y/N

CURRENT STRESS LEVELS

HOW DO YOU PERCEIVE THE CURRENT STRESS IN YOUR LIFE? _____ [SCALE 0-10]

WHAT ARE THE MAIN STRESSORS IN YOUR LIFE? _____

HOW DOES IT MANIFEST IN YOUR BODY / LIFE? _____

HOW DO YOU MANAGE IT? _____

DO YOU CURRENTLY WORK WITH A COUNSELOR / THERAPIST? _____

NAME OF COUNSELOR / THERAPIST: _____ PHONE: _____

RELAXATION AND SLEEP

WHAT DO YOU DO TO RELAX? [HOBBIES, MEDITATION, PRAYER, EXERCISE, ETC.] _____

WHAT DO YOU DO TO HAVE FUN AND JOY IN YOUR LIFE? _____

DESCRIBE AN AVERAGE NIGHT'S SLEEP: _____

DO YOU WAKE FEELING COMPLETELY RESTED? YES / NO

DO YOU CURRENTLY HAVE INSOMNIA? YES / NO

DO YOU USE ANY SLEEP AIDS/MEDICATION? YES / NO TYPE? _____

HAVE YOU PREVIOUSLY HAD INSOMNIA? YES / NO

DO YOU SLEEP WITH THE TV ON? YES / NO

DO YOU HAVE DIFFICULTY FALLING ASLEEP? YES / NO

DO YOU HAVE DIFFICULTY STAYING ASLEEP? YES / NO

IF SO, WHAT TIME DO YOU SEEM TO WAKE EACH NIGHT? _____ NIGHTS PER WEEK? _____

EXERCISE AND MOVEMENT

DO YOU HAVE ANY SPECIAL NEEDS OR LIMITATIONS I SHOULD BE AWARE OF? YES / NO

PLEASE LIST SPECIFICS: _____

DO YOU WALK REGULARLY? YES / NO NUMBER OF DAYS PER WEEK: _____

DO YOU CURRENTLY EXERCISE? YES / NO

IF SO, HOW DO YOU LIKE TO EXERCISE? _____

DO YOU STRENGTH TRAIN [LIFT WEIGHTS] REGULARLY? YES / NO NUMBER OF DAYS: _____

DO YOU DO CARDIO EXERCISES REGULARLY? YES / NO NUMBER OF DAYS: _____

DO YOU TRAIN YOUR 'CORE' MUSCLES REGULARLY? YES / NO NUMBER OF DAYS: _____

[YOGA, PILATES, BALANCE BALL, TAI QI, ETC.]

SOCIAL HISTORY

DO YOU HAVE A GOOD SUPPORT NETWORK IN YOUR LIFE? YES / NO

DO YOU HAVE CLOSE FRIENDS IN YOUR LIFE? YES / NO

ARE YOU INVOLVED IN ANY CLUBS, GROUPS, OR MEETINGS [OUTSIDE WORK]? YES / NO

DO YOU HAVE A FAMILY? YES / NO

CHILDREN? YES / NO

DO YOU FOLLOW A RELIGIOUS BELIEF? YES / NO

IF SO, DO YOU REGULARLY ATTEND SERVICES? YES / NO

ARE YOU CURRENTLY IN A RELATIONSHIP? YES / NO
ARE YOU? SINGLE MARRIED HAVE A PARTNER SEPARATED DIVORCED WIDOW/ER

ARE YOU SEXUALLY ACTIVE? YES / NO PARTNERS: MALE / FEMALE / BOTH
DO YOU PRACTICE SAFE SEX? YES / NO TYPE OF BIRTH CONTROL? _____
HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE [STD]? _____

DO YOU DRINK ALCOHOL? YES / NO
IF SO, WHICH TYPE? WINE / BEER / LIQUOR NUMBER OF DRINKS PER WEEK: _____
HAVE YOU EVER HAD AN ADDICTION TO ALCOHOL? YES / NO

DO YOU SMOKE CIGARETTES? YES / NO
IF SO, HOW MANY PACKS PER DAY? _____ PACKS
WHEN DID YOU BEGIN TO SMOKE? _____ YEARS OLD
ARE YOU INTERESTED IN TREATMENT TO QUIT SMOKING? YES / NO

DO YOU USE RECREATIONAL DRUGS? YES / NO
IF SO, WHAT TYPE? _____ HOW FREQUENTLY? _____
HAVE YOU SOUGHT TREATMENT FOR ADDICTION? YES / NO

DO YOU REGULARLY USE YOUR SEATBELT? YES / NO
DO YOU HAVE A WORKING SMOKE DETECTOR IN YOUR HOUSE? YES / NO
HAS IT BEEN TESTED ANNUALLY? YES / NO
DO YOU HAVE A WORKING CARBON MONOXIDE DETECTOR? YES / NO

SUMMARY

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD THAT YOU FEEL IS IMPORTANT FOR ME TO UNDERSTAND YOUR CURRENT STATE OF HEALTH?

PLEASE FEEL FREE TO CALL WITH ANY QUESTIONS! 917-733-5939