Solace Natural Medicine, PLLC **New Patient Information** **Today's Date________**

First Name________________________M.I.__________Last Name________________________

Gender_______Birth Date__________________Social Security(optional)____________________

Address____

City______________________________State________________Zip________________________

Email____________________________Phone (Home)____________(Cell)__________________

Occupation________________________Phone (Work)___________________________________

Relationship Status: Married/Partnered Divorced/Separated Single/Widowed

Name of Spouse/Significant Other____

Who do you live with? ____

Parent / Guardian (if patient is a Minor)____

In Case of Emergency Contact____

How did you hear about us?____

Medical Information **(if more space is needed, please continue on the back side of this form)**

What is your main reason for coming in today?____

____

Please list any medical care you have received lately (include names of other health professionals)

____

____

Allergies (**Medication, Food, Environment**)____

____

Mo/Yr of last medical exam_________________Last Blood Tests_____________Blood Type____

For women: Last Pap____________________Mammogram_________Menses ______________

Describe menses: Regular_______Irregular___________PMS_________Menopausal _________

Describe any abnormal labs, x-rays, or other tests______________________________________

____

List Hospitalizations or Surgeries:____

____

Do you use:	Y/N	AMOUNT		Y/N	AMOUNT
Alcohol			Coffee/Caffeine		
Pain Relievers			Tobacco Current/Past		
Antacids			Sleeping Aids		
Recreational Drugs			Appetite Suppressants		
Laxatives			Sugar		

Have you unsuccessfully tried to stop using any of the above items?__________________

Circle all personal health conditions that apply to you now or in the past

asthma	gastric ulcer	bronchitis	headaches
osteoporosis	ear infections	infertility	nervous break down
tuberculosis	skin problems	hormone imbalance	hepatitis A, B, or C
bowel problems	crohn's disease	IBS	chronic fatigue
rheumatic fever	STD's	candida	immune dysfunction
insomnia	pneumonia	scarlet fever	herpes
epilepsy	ADD/ADHD	erectile dysfunction	endometriosis
colitis	fibromyalgia	shingles	chicken pox

Personal and Family Health History

Disease	Self	Mother/Father	Brother/Sister	Child	Uncle/Aunt	Grandparent Maternal/Paternal
Alcohol/Drug Abuse						
Allergies/Sinus						
Anemia/Bld Disorder						
Arthritis						
Birth Defect						
Diabetes						
Depression/Anxiety						
Emotional Disorder						
High Cholesterol/Fat						
Heart Disease						
High Blood Pressure						
Obesity						
Thyroid Disorder						
Stroke						
Cancer						

Other health conditions or body sensations you are experiencing?___________________________________

____

____

____

How many hours do you sleep?_____________Quality?______________________________

Rate your energy level (1 low – 10 high)?____

How much water do you drink each day?____________Other beverages?__________________

Do you exercise? Types___________________________Frequency__________________

Any weight issues?__________Current weight_____________Highest lifetime weight_______

How many hours do you work each week____________Do you enjoy your work?____________

Do you have a religious or spiritual practice?____

Any experiences (traumatic or otherwise) that did or still do affect you deeply? Explain if you wish?____

____

Please use the chart below to list all current prescription medications followed by herbs and dietary supplements.

Medication/Supplements	**Dosage**	**For what Purpose?**	**How long have you taken it?**	**Prescribed by: Dr's name or self**	**Side Effects**

Please use the chart below to detail your typical daily diet.

What do you eat on a typical day?	
Breakfast	
Mid-morning snack	
Lunch	
Mid-afternoon snack	
Supper	
Evening snack	
Other:	

What do you think causes or has contributed to your health problems?______________________________
____
____
____

Which statement best describes your attitude to your health?
_______I'll do whatever it takes to obtain optimal health
_______I'm willing to change my lifestyle somewhat to feel better
_______I may consider change, if needed, to feel better
_______Just give me a pill, doc

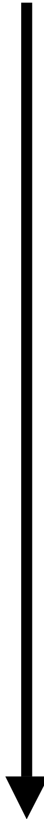
Is there anything else you'd like to add?

Your Wellness Biography

The top is your birth, the bottom is your present. On the left, please mark major health events such as surgeries, hospitalizations, accidents/injuries, illnesses, etc. On the right, please mark major social events such as marriages, childbirth, relocations, occupational changes, educational milestones, etc. Include the age you experienced each event.

Health Biography	Social Biography
Injury, illness, surgery, auto accidents, times of best health, etc.	Stress, best times, graduations, marriage, divorce, births, deaths, moves, job changes, etc.

BIRTH



PRESENT

Thank you for taking the time to complete this form.
We look forward to providing you with the best possible care.