

PATIENT INFORMATION

Last Name: _____

First Name: _____

Parent/Guardian of patient?

Name and Relationship to Patient:

Today's Date: _____ / _____ / _____ Male Female

S.S.# _____

Date of Birth: _____ / _____ / _____

Status: Single Married Divorced Widowed Other _____

Primary Number: _____ Home: _____ Cell/Alternate: _____

Fax: _____ Work: _____

E-mail: _____

REFERRED BY (specify)

Name: _____

Physical Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

CONFIDENTIALITY AND PAYMENT AGREEMENT

Last Name: _____

First Name: _____

DOB _____ / _____ / _____

Today's Date _____ / _____ / _____

I am passionate about strictly protecting the confidentiality of all my patients. I also strongly emphasize an integrative approach to wellness, prevention, diagnosis and treatment of disease. Therefore, it is of significant importance that I discuss the various treatment modalities that I may employ to treat you with a physician or other health professional.

I authorize Elissa Goodman to discuss my diagnosis & treatment options with:

My Physician: _____

External Practitioner(s)

I have read and agree to the above terms and conditions.

Print Name: _____ Signature: _____

I. GOALS: What would you most like to achieve through your work with Elissa Goodman?

- 1. _____
- 2. _____
- 3. _____

II. MAJOR SYMPTOMS: Please list in order of importance what symptoms are of concern to you. (most concerning to least, along with the duration of the symptom)

- 1. _____
- 2. _____
- 3. _____

MEDICAL HISTORY (please check all that apply and include date diagnosed)

- Diabetes _____ / _____ / _____
- Heart Disease _____ / _____ / _____
- High Blood Pressure _____ / _____ / _____
- High Cholesterol _____ / _____ / _____
- Thyroid Disease _____ / _____ / _____
- Seizures _____ / _____ / _____
- Cancer _____ / _____ / _____
- Hepatitis _____ / _____ / _____
- HIV _____ / _____ / _____
- Others _____ / _____ / _____

SURGICAL HISTORY (please list any surgical procedure and date)

Date _____

MEDICATIONS / SUPPLEMENTS

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

ALLERGIES (to medications, chemicals or foods):

NUTRITION

1. Do you follow a special diet? Yes No

If yes, how would you describe the diet?

(ie, Vegetarian, Vegan, Low Carb, etc.)

2. What do you eat on a “typical” day?

a) Breakfast _____

b) Lunch _____

c) Dinner _____

d) Snacks _____

e) Foods you tend to crave: _____

f) Foods you dislike: _____

SOCIAL HISTORY

1. How much per day do you use of the following?

a) Coffee, tea, soft drinks: _____

b) Alcohol: _____

c) Cigarettes, cigars, other tobacco: _____

d) Other drugs: _____

2. Have you ever had a problem with alcohol or alcoholism? Yes No

3. Have you ever had a problem with dependency on other drugs? Yes No

4. If yes which and when?

5. Do you have a known history of any exposure to toxic substances? Yes No

6. If so, please list which and when you first noticed symptoms? _____

7. In the past year, how many days have been significantly affected by your health? _____

INTAKE FORM

8. How many days did you feel generally poor? _____

9. How many times were you in the hospital? _____

10. Please describe your current exercise regimen:

Hours per week: _____

Activities: _____

11. How many hours of sleep do you usually get per night during the week? _____

12. Do you awake feeling rested? Yes No

Do you feel you sleep well at night? Yes No

13. Who would you describe as your source of primary social support? (relationship to you):

OCCUPATION

Employed Title/Description _____

Length of time at current job _____ Unemployed Full-time Parent

Level of enjoyment with job: Very high High Moderate Low Very low

Stress Level at job: Very high High Moderate Low Very low

OTHER INFORMATION

Previous Complementary Medicine Experiences: Yes No

Please describe diagnosis and approximate dates of any previous treatment.

