ARTHRITIS Health
*Comprehensive Care*


*Rheumatology*
Paul F. Howard, MD, FACP, FACR
Nisha Manek, MD MRCP
Amanda Herron, PA-C

*Naturopathy & Acupuncture*
Leslie Axelrod, NMD, L.Ac.
Keith Wilkinson, NMD

*Yoga Therapy*
Ginnie Livingston, RN, MSN, CYT
Ellen Martinoni, CYI, RYT
Kimberly Howard, CYT
Sherry Petersen, CYT


Dear Patient,

Thank you for your interest in naturopathic care at Arthritis Health and the opportunity to work with you. Naturopathic medicine is an approach to health care that provides an array of treatment options. However, more importantly, I believe naturopathic medicine offers a distinctly different way to thinking about health.

The following pages are the start of our comprehensive discussion to learn about you. This form is somewhat long, but I appreciate your time to thoughtfully answer these questions.

The first office visit is where we gather the largest amount of information. Accordingly, this visit can last 1 ½ to 2 hours. In order for me to prepare for this visit, I kindly request that this form be mailed or faxed to Arthritis Health at least 2 days prior to your first appointment. Additionally, if you are taking any supplementation/medications, have recent laboratory work or pertinent medical records, please bring these to the visit.

Thank you again for your interest in working with me. I look forward to meeting you.

Sincerely,

C. Keith Wilkinson, NMD
*Naturopathic Physician*


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Scottsdale, Arizona 85260

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ARTHRITIS Health

Comprehensive Care

*Rheumatology • Naturopathy • Acupuncture • Yoga Therapy*

# New Patient Form – ADULT

Date: _____

## Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # Home: _____ Cell: _____ Work: _____

E-mail address: _____

Age: _____ DOB: _____ Gender: ☐ M ☐ F

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partner

Live With: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Occupation: _____ Hours per week: _____ ☐ Retired/Not Working

Employer: _____

## Additional Information

Primary Care Physician: _____ Phone #: _____

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

Emergency Contact: _____

Relationship to You: _____ Contact #: _____

## Referral Information

How did you hear about Dr. Wilkinson? _____

Were You Referred by a Physician? ☐ Y ☐ N

If yes, could you provide us with information for the referring physician?

Referring Physician's Name: _____

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

Telephone Number: _____

*The following questions will help me understand your expectations.*

1. Why did you choose to come to Arthritis Health?

2. What do you know about naturopathic medicine?

3. What expectations do you have from this initial visit?

4. What long term expectations do you have regarding your health?

5. Any other expectations you have that I should know about?

6. What is your present level of commitment to address any underlying causes of your health concerns that relate to your lifestyle? (Rate 0 - 10, 10 = 100% committed)
   *0 1 2 3 4 5 6 7 8 9 10*

7. What lifestyle habits do you currently engage in that you believe support your health?

8. What lifestyle habits do you currently engage in that you believe harm your health?

9. What potential obstacles do you foresee in addressing the lifestyle factors which may undermine your health and/or adhering to therapeutic protocols we might try?

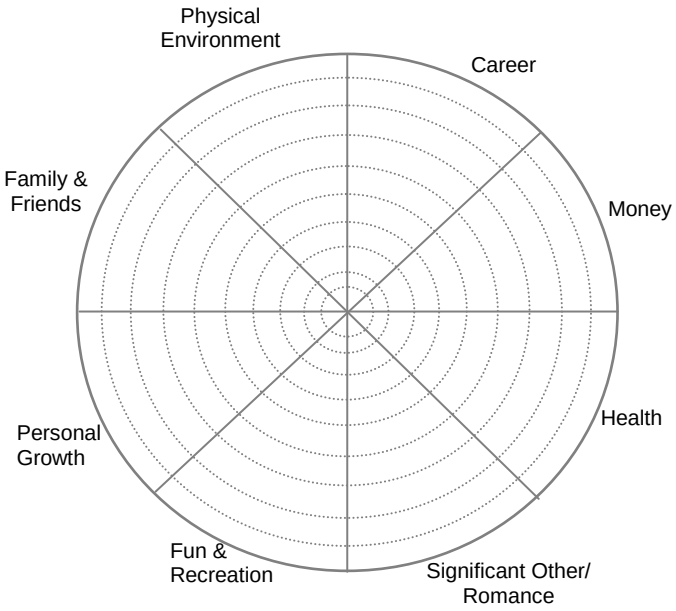
10. Who do you know that will consistently support you with lifestyle changes we might try?

## Total Wellness Graph

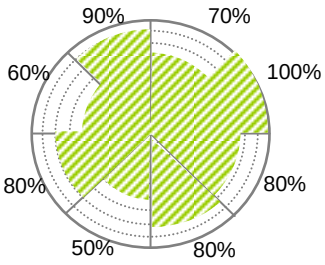
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.




Example:




Are you currently receiving medical care? Y N

If yes, where and from whom: _____

_____

If no, when and where did you last receive medical care? _____

_____

What was the reason? _____

What are your most important health problems? List in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

## Family History

| | Father | Mother | Siblings | Mat/Paternal Grand M/F | | | | Spouse | Children |
|---|---|---|---|---|---|---|---|---|---|
| | | | | MGM | MGF | PGM | PGF | | |
| Age if living: | | | | | | | | | |
| Age when died: | | | | | | | | | |
| Reason for death: | | | | | | | | | |
| If cancer, type: | | | | | | | | | |

*If has condition in column on left, place an X in the appropriate box below.*

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| High Blood Pressure: | | | | | | | | | |
| Heart Attack/Stroke: | | | | | | | | | |
| Heart Disease: | | | | | | | | | |
| Asthma/Allergies: | | | | | | | | | |
| Mental Illness: | | | | | | | | | |
| Auto-Immune Disease: | | | | | | | | | |
| Diabetes Mellitus: | | | | | | | | | |
| Osteoporosis: | | | | | | | | | |

## Childhood Illnesses

Did you have the following **D**isease (**D**), **I**mmunized (**I**), or **N**either (**N**):

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Hepatitis (A / B) | D I N | Varicella (Chicken Pox) | D I N | Hemophilus (Hib) | D I N |
| Rotavirus | D I N | Diptheria (DTaP) | D I N | Measles (MMR) | D I N |
| Pneumococcal (PCV) | D I N | Tetanus (DTaP) | D I N | Mumps (MMR) | D I N |
| Polio (IPV) | D I N | Pertussis (DTaP) | D I N | Rubella (MMR) | D I N |

Did you have any significant reaction to any immunization? ☐ Y ☐ N

If yes, explain: _____

## Doctor, Hospitalization, Surgery, Imaging

**Please Note When & Why You Have Had Each of the Following:**

X-Rays: _____ MRI/CT Scans: _____

Ultrasounds: _____ EKG: _____

TB Test: _____ Last Doctor Visit: _____

Last Dental Visit: _____ Last Eye Exam: _____

List any other major illness, trauma, medical interventions not yet mentioned:

_____

_____

## Allergies

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any substances in the environment or chemicals? _____

Have you ever had allergy testing? If yes, indicate when and details. _____

## Current Medications / Supplements

| **Prescription Medications** | | | **OTC Medications** (i.e., Ibuprofen, Tums) | | |
|---|---|---|---|---|---|
| *Name* | *Dosage* | *Since* | *Name* | *Dosage* | *Since* |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| **Supplements** | | | **Other/Additional Space** | | |
|---|---|---|---|---|---|
| *Name* | *Dosage* | *Since* | *Name* | *Dosage* | *Since* |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## General

Current Height: _____ / Weight:_____ Weight 1 year ago: _____

Maximum Weight: _____When: _____ Ideal Weight: _____ When: _____

Do you have sufficient energy throughout day? Y N If not, when is energy best?_____ Worst? _____

## Habits/Lifestyle

Main interests and hobbies?_____

Do you exercise? Y N

If yes, what kind/how often?_____

| | | | |
|---|---|---|---|
| Hours of sleep each night? | _____ | Enjoy your work? | Y N |
| Sleep well? | Y N | Take vacations? | Y N |
| Awake rested? | Y N | Spend time outside? | Y N |
| Do you need naps during day? | Y N | How many hours of TV per day? | _____ |
| If nap, how long/often? | _____ | How much time/day in relaxation? | _____ |
| Have a supportive relationship? | Y N | Do you eat 3 meals a day? | Y N |
| Have a history of abuse? | Y N | Do you go on diets often? | Y N P |
| Been treated for drug dependence? | Y N P | Do you eat out often? | Y N |
| Use alcoholic beverages? | Y N P | Do you drink coffee? | Y N P |
| Treated for alcoholism? | Y N P | Drink black/green tea? | Y N P |
| Do you use tobacco? | Y N P | Do you drink sodas? | Y N |
| How many years and packs/day ? | _____ | If yes, quantity per day or week. | _____ |
| Do you have a religious/spiritual practice? | Y N P | Do you have a sweet tooth? | Y N P |
| If yes, what? | _____ | If yes, what and quantity per day/week | _____ |

**note - Y =** a condition you <u>have now</u> **N =** Never had **P =** <u>Significant</u> problem in the past

## Environmental Exposure

Did you grow up in an industrial area such as chemical factories, refineries, agriculture, etc.? Y N
If yes, name the type of industry._____

Do you currently live in an area where you are exposed to possible environmental pollutants? Y N
If yes, name the type of industry. _____

Do you work in an environment where you are exposed to solvents, fumes, paint, chemicals etc.? Y N
If yes, provide detail. _____

Have you ever had problems when exposed to new carpeting, new paint, gasoline, etc.? Y N
If yes, provide detail. _____

Are you particularly sensitive to perfumes, new cars, other odors? Y N
If yes, provide detail. _____

Do you use pesticides, herbicides, or other chemicals around your home? Y N
If yes, provide detail. _____

## REVIEW OF SYSTEMS

### Mental / Emotional

| | | | |
|---|---|---|---|
| Treated for emotional problems? | Y N P | Depression? | Y N P |
| Mood Swings? | Y N P | Anxiety or nervousness? | Y N P |
| Considered/Attempted suicide? | Y N P | Tension? | Y N P |
| Poor concentration? | Y N P | Memory problems? | Y N P |

### Immune

| | | | |
|---|---|---|---|
| Reactions to immunizations? | Y N P | Reactions to vaccinations? | Y N P |
| Chronic fatigue? | Y N P | Chronic infections? | Y N P |
| Chronically swollen glands? | Y N P | Slow wound healing? | Y N P |

### Endocrine

| | | | |
|---|---|---|---|
| Hypothyroid? | Y N P | Heat or cold intolerance? | Y N P |
| Hypoglycemia? | Y N P | Diabetes? | Y N P |
| Excessive thirst? | Y N P | Excessive hunger? | Y N P |
| Fatigue? | Y N P | Seasonal depression? | Y N P |

### Neurologic

| | | | |
|---|---|---|---|
| Seizures? | Y N P | Paralysis? | Y N P |
| Muscle weakness? | Y N P | Numbness or tingling? | Y N P |
| Loss of memory? | Y N P | Easily stressed? | Y N P |
| Vertigo or dizziness? | Y N P | Loss of balance? | Y N P |

### Skin

| | | | |
|---|---|---|---|
| Rashes? | Y N P | Eczema/Hives? | Y N P |
| Acne, Boils? | Y N P | Itching? | Y N P |
| Color Change? | Y N P | Perpetual hair loss? | Y N P |
| Lumps? | Y N P | Night Sweats? | Y N P |

### Head

| | | | |
|---|---|---|---|
| Headaches? | Y N P | Head Injury? | Y N P |
| Migraines? | Y N P | Jaw/TMJ problems | Y N P |

**note - Y =** a condition you have now **N =** Never had **P =** Significant problem in the past

## Eyes

| | | | |
|---|---|---|---|
| Spots in Eyes? | Y N P | Cataracts? | Y N P |
| Impaired vision? | Y N P | Glasses or contacts? | Y N P |
| Blurriness? | Y N P | Eye pain/strain? | Y N P |
| Color blindness? | Y N P | Tearing or dryness? | Y N P |
| Double Vision? | Y N P | Glaucoma? | Y N P |

## Ears

| | | | |
|---|---|---|---|
| Impaired hearing? | Y N P | Ringing? | Y N P |
| Earaches? | Y N P | Dizziness? | Y N P |

## Nose and Sinuses

| | | | |
|---|---|---|---|
| Frequent colds? | Y N P | Nose Bleeds? | Y N P |
| Stuffiness? | Y N P | Hayfever / Post Nasal Drip? | Y N P |
| Sinus problems? | Y N P | Loss of smell? | Y N P |

## Mouth and Throat

| | | | |
|---|---|---|---|
| Frequent sore throat? | Y N P | Copious saliva? | Y N P |
| Teeth grinding? | Y N P | Sore tongue/lips? | Y N P |
| Gum problems? | Y N P | Hoarseness? | Y N P |
| Dental cavities? | Y N P | Jaw clicks? | Y N P |

## Neck

| | | | |
|---|---|---|---|
| Lumps? | Y N P | Swollen glands? | Y N P |
| Goiter? | Y N P | Pain or stiffness? | Y N P |

## Respiratory

| | | | |
|---|---|---|---|
| Cough? | Y N P | Sputum? | Y N P |
| Spitting up blood? | Y N P | Wheezing | Y N P |
| Asthma? | Y N P | Bronchitis? | Y N P |
| Pneumonia? | Y N P | Pleurisy? | Y N P |
| Emphysema? | Y N P | Difficulty breathing? | Y N P |
| Pain on breathing? | Y N P | Shortness of breath? | Y N P |
| Shortness of breath at night? | Y N P | Shortness of breath lying down? | Y N P |
| Tuberculosis? | Y N P | | |

## Cardiovascular

| | | | |
|---|---|---|---|
| Heart disease? | Y N P | Angina? | Y N P |
| High/Low Blood Pressure? | Y N P | Murmurs? | Y N P |
| Blood clots? | Y N P | Fainting? | Y N P |
| Phlebitis? | Y N P | Palpitations/Fluttering? | Y N P |
| Rheumatic Fever? | Y N P | Chest pain? | Y N P |
| Swelling in ankles? | Y N P | | |

## Gastrointestinal

| | | | |
|---|---|---|---|
| Trouble swallowing? | Y N P | Heartburn? | Y N P |
| Change in thirst? | Y N P | Abdominal pain or cramps? | Y N P |
| Change in appetite? | Y N P | Belching or passing gas? | Y N P |
| Nausea/vomiting | Y N P | Constipation? | Y N P |
| Ulcer? | Y N P | Diarrhea? | Y N P |
| Jaundice (yellow skin)? | Y N P | Bowel Movements: How many per day? | _____ |
| Gall Bladder disease? | Y N P | Black stools? | Y N P |
| Liver Disease? | Y N P | Blood in stool? | Y N P |
| Hemorrhoids? | Y N P | | |

**note - Y =** a condition you have now **N =** Never had **P =** Significant problem in the past

## Urinary

| | | | |
|---|---|---|---|
| Pain on urination? | Y N P | Increased frequency? | Y N P |
| Frequency at night? | Y N P | Inability to hold urine? | Y N P |
| Frequent infections? | Y N P | Kidney stones? | Y N P |

## Musculoskeletal

| | | | |
|---|---|---|---|
| Joint pain or stiffness? | Y N P | Arthritis? | Y N P |
| Broken bones? | Y N P | Weakness? | Y N P |
| Muscle spasms or cramps? | Y N P | Sciatica? | Y N P |

## Blood / Peripheral Vascular

| | | | |
|---|---|---|---|
| Easy bleeding or bruising? | Y N P | Anemia? | Y N P |
| Deep leg pain? | Y N P | Cold hands/feet? | Y N P |
| Varicose veins? | Y N P | Thrombophlebitis? | Y N P |

## Male Reproduction

| | | | |
|---|---|---|---|
| Hernias? | Y N P | Testicular masses? | Y N P |
| Testicular pain? | Y N P | Prostate disease? | Y N P |
| Venereal disease? | Y N P | Discharge or sores? | Y N P |
| Are you sexually active? | Y N | Chlamydia? | Y N P |
| Sexual orientation: _____ | | Gonorrhea? | Y N P |
| Impotence? | Y N P | Condyloma? | Y N P |
| Premature ejaculation? | Y N P | Herpes? | Y N P |
| Birth control? Type? _____ | | Syphilis? | Y N P |

## Female Reproduction / Breasts

| | | | |
|---|---|---|---|
| Age of first menses? _____ | | Date of last annual exam / PAP _____ | |
| Age of last menses? (if menopausal) _____ | | Are cycles regular? | Y N |
| Length of cycle? _____ days | | Bleeding between cycles? | Y N P |
| Duration of menses? _____ days | | Pain during intercourse? | Y N P |
| Painful menses? | Y N P | Clotting? | Y N P |
| Heavy or excessive flow? | Y N P | Discharge? | Y N P |
| PMS? | Y N P | Birth control? | Y N P |
| If yes, what are your symptoms? | | What type? _____ | |
| _____ | | Number of pregnancies: _____ | |
| _____ | | Number of live births: _____ | |
| Endometriosis? | Y N P | Number of miscarriages: _____ | |
| Ovarian cysts? | Y N P | Number of abortions: _____ | |
| Difficulty conceiving? | Y N P | Menopausal symptoms? | Y N P |
| Cervical Dysplasia? | Y N P | Abnormal PAP? | Y N P |
| Sexual difficulties? | Y N P | Chlamydia? | Y N P |
| Gonorrhea? | Y N P | Condyloma? | Y N P |
| Herpes? | Y N P | Syphilis? | Y N P |
| Are you sexually active? | Y N | Sexual orientation: _____ | |
| Do you do breast self exams? | Y N P | Breast lumps? | Y N P |
| Breast pain/tenderness? | Y N P | Nipple discharge? | Y N P |

Is there anything else you would like to add or comment on?

_____

_____

_____

_____

**Thank you for completing this form. See you at Arthritis Health.**