



Rheumatology

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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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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?

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2. What do you know about naturopathic medicine?

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

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

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

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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?

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

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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?

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

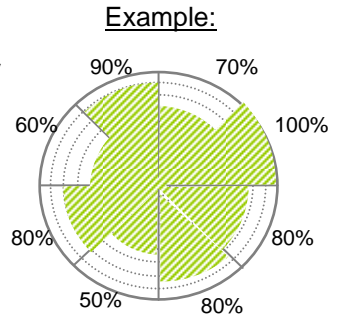
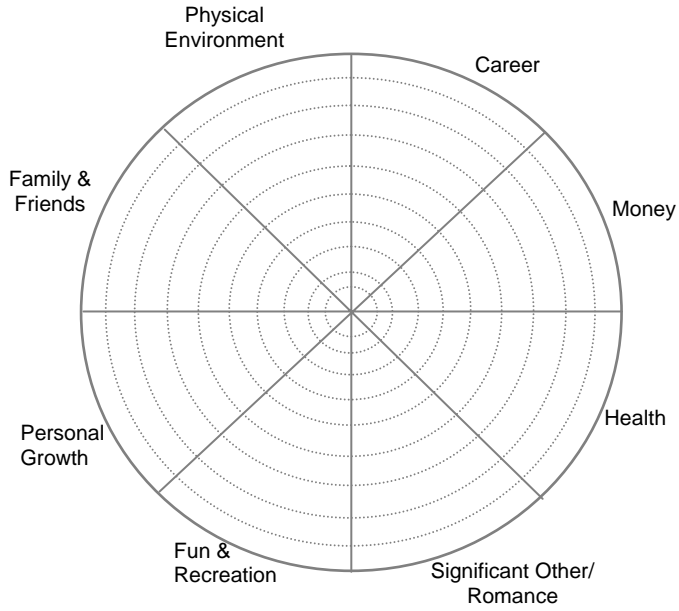
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**Total Wellness Graph**

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.



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

Age if living:  
 Age when died:  
 Reason for death:  
 If cancer, type:

Father	Mother	Siblings	Mat/Paternal Grand M/F				Spouse	Children
			MGM	MGF	PGM	PGF		

*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 Disease (D), Immunized (I), or Neither (N):

Hepatitis (A / B)	D I N	Varicella (Chicken Pox)	D I N	Hemophilus (Hib)	D I N
Rotavirus	D I N	Diphtheria (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

Please list any prescription, over the counter medications, or vitamins/supplements you are taking and dosages.

Prescription Medications	OTC Medications (Ibuprofen, antacids, sleep aid, laxative, etc.)	Vitamins/Supplements
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
9.	9.	9.
10.	10.	10.

### 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? \_\_\_\_\_

Sleep well?      Y N

Awake rested?      Y N

Do you need naps during day?      Y N

If nap, how long/often? \_\_\_\_\_

Have a supportive relationship?      Y N

Have a history of abuse?      Y N

Been treated for drug dependence?      Y N P

Use alcoholic beverages?      Y N P

Treated for alcoholism?      Y N P

Do you use tobacco?      Y N P

How many years and packs/day ? \_\_\_\_\_

Do you have a religious/spiritual practice?      Y N P

If yes, what? \_\_\_\_\_

Enjoy your work?      Y N

Take vacations?      Y N

Spend time outside?      Y N

How many hours of TV per day? \_\_\_\_\_

How much time/day in relaxation? \_\_\_\_\_

Do you eat 3 meals a day?      Y N

Do you go on diets often?      Y N P

Do you eat out often?      Y N

Do you drink coffee?      Y N P

Drink black/green tea?      Y N P

Do you drink sodas?      Y N

If yes, quantity per day or week. \_\_\_\_\_

Do you have a sweet tooth?      Y N P

If yes, what and quantity per day/week \_\_\_\_\_

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

<b>note - Y = a condition you have now      N = Never had      P = Significant problem in the past</b>
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### 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
Stiffness?	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?

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

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[www.arthritishealth.net](http://www.arthritishealth.net)

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