Natural Healthcare Specialties *"Serving the East Valley since 1984"*
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Dear Prospective Practice Member, Welcome! *Please answer the following questions to the best of your ability. Understanding your health concerns, health goals and health attitudes is the first step in determining how we can support you. Please note that your personal files will be kept strictly confidential and only Drs. Pete & Amy will have access to this form.*

Practice Member Registration Form

Name: _____ Date: _____

(If patient is a minor, parents' names: _____)

Home Address: _____ City_____ State____ Zip_____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____ Occupation: _____

Date Of birth: _____ Present Age: _____ Height: _____ Weight: _____

Marital Status: S M D W P **#** of children: _____ Family Physician: _____

Referred By: _____(friend, co-worker, sign, internet, advertising, phone book)

Please state your primary reason for coming to our health center. What are your main goals?

_____

_____

_____

Please list your major health concerns in order of importance.

1.

2.

3.

4.

5.

6.

Brief Symptom Overview

In addition to your primary concerns:

Please mark the typical symptoms that show up from time to time when you are "stressed out" or feeling "run down" with an **"X"**

Please mark all symptoms that have become a chronic, long term, persistent, normal part of your life with a **"XX"**

H Headaches
Faintness
Dizziness
Insomnia

E Watery or itchy eyes
Swollen, reddened or sticky eyelids
Bags or dark circles under eyes
Blurred or tunnel vision
(not include near or far sightedness)

E Itchy ears
Earaches, ear infections
Drainage from ear
Ringing in ears, hearing loss

N Stuffy nose
Sinus problems
Hay fever
Sneezing attacks
Excessive mucus formation

T Chronic coughing
Gagging, frequently need to clear throat
Sore throat, hoarseness, loss of voice
Swollen or discolored tongue, gums, lips
Canker sores
Dental problems

S Acne
Hives, rashes, dry skin
Hair loss
Flushing, hot flashes
Excessive sweating

H Irregular or skipped heartbeat
Rapid or pounding heartbeat
Chest pain

L Chest congestion
Asthma, bronchitis
Shortness of breath
Difficulty breathing

D Nausea, vomiting
Diarrhea
Constipation
Bloated feeling
Heartburn
Intestinal/stomach pain

J Pain or aches in joints
Spinal pain & stiffness
Limitation of movement
Pain or aches in muscles
Physical weakness/tiredness

W Binge eating/drinking
Craving certain foods
Excessive weight
Compulsive eating
Water retention
Underweight

E Fatigue, sluggishness
Apathy, lethargy
Hyperactivity
Restlessness

M Poor memory, confusion
Poor comprehension
Poor concentration
Poor physical coordination
Difficulty in making decisions
Stuttering or stammering
Slurred speech
Learning disabilities

E Mood swings
Anxiety, fear, nervousness
Anger, irritability, aggressive
Depression

O Frequent illness
Frequent or urgent urination
Genital itch or discharge

Other:_____

Office Use:

Please complete the following for both your primary concerns and secondary complaints, if it applies to you.

Is there anyone else in your family who suffers from similar health challenges to you or to any of the symptoms mentioned above?

Who? What Problem? Care he/she is receiving?

Before you began to suffer from your primary and secondary complaints, was there any Physical, Chemical or Emotional Stress that may have triggered or contributed to your health challenges? (Ex. Trauma from accidents/injuries/surgeries, Toxin or allergy exposure from food, drink, drugs: prescription, over-the-counter or recreational, and/or Emotional overload or mental strain circumstances). Comments:

Since you began to suffer from your primary and secondary complaints, what, if anything, have you tried to do to help that has not worked permanently? (Ex. Ice, heat, rest, over-the-counter meds, prescriptions, P.T., supplements). Comments:

Did these give you temporary relief? Yes No

The following questions are about how your health challenges or general state of health affect your life so that we can better measure your progress and the benefits of your care here in the future.

When your health challenges or general state of health is at its worst, which of the following does it affect? Normal daily activities___, Productivity or performance at work___, Sleep___, Relationships___, Prevents you from doing things you enjoy such as hobbies or special interests___. Comments:

Are there things that you would try, or do more of if it weren't for these problems? Comments:

Do you feel that your health concerns or current state of health is: worsening ___, staying the same ___, or improving ___? Comments:

So that we have a better idea of how you see your care here progressing:

Why did you choose Natural Healthcare Specialties to support your health?
What do you know about Dr. Pinto's whole body / whole health approach?

Do you agree that a different approach than what you have already tried is going to be necessary to get rid of your health problems completely? Yes No Comments:

On a scale of 1 – 10 (ten being the most) how much so do you want to get rid of your health problems completely? _____ Comments:

Your attitude about your health is as important to us as the specific reasons you've consulted our office. Below are four prevalent health attitudes. Please mark the ones that most closely reflect your personal values or that you would like to investigate.

- ☐ Symptom Relief Care Only – I only consult a practitioner when I have an ache or pain and discontinue treatment as soon as it has cleared up.
- ☐ Corrective Care When Possible – In addition to symptomatic treatment, I consult practitioners to help detect and correct the "upstream" causes of my symptoms, working toward preventing problems from recurring.
- ☐ Pro-active Wellness Care – I am conscious about my health, diet, exercise, etc. and actively pursue keeping "tuned up" because it makes me feel better, perform better, gain clarity and it maximizes my potential.
- ☐ Family Preventive Care – I take an active part in assisting, informing and maintaining health, with my family. Understanding and utilizing the long term effects of good health is a priority to me.

Assuming we can help you with your health problems, is there anything that may prevent you from following through with a wellness plan here at Natural Healthcare Specialties? Yes No (Ex.- time, transportation, etc.) Comments:

I certify that the information provided on this form is correct to the best of my knowledge.

_____ _____
Signature Date

Office Use: