Santa Cruz Naturopathic Medical Center

Hello-

Welcome to the Santa Cruz Naturopathic Medical Center! You can read more about us and our center at www.scnmc.com.

Attached are forms to complete before your appointment. Please bring these completed forms with you at the time of your appointment, and also bring any medications, herbs, and/or supplements you are currently taking. Please also bring copies of any recent laboratory test results. If you have had labs but do not have the results, we will have you sign a release of record and we can obtain those for you.

An exam for acute illness usually lasts one hour and costs $150. You may also receive supplements on your first visit (i.e. vitamins, herbs, homeopathics, etc.) for an additional charge. Payment is due in full at the time of the visit. If you have insurance, we will submit a superbill to your insurance on your behalf requesting reimbursement for the office visit. You may or may not receive partial reimbursement, depending on your insurance provider and your particular plan.

Our clinic is located at 736 Chestnut Street in Santa Cruz, CA 95060. If you need further directions, or if you have any questions, please don't hesitate to call.

We look forward to seeing you at your appointment and partnering with you in your health.

Please note:
If you need to cancel your appointment, we require a 24 hour notice. You will be charged a $75 cancellation fee for a missed appointment or cancelling with less than 24 hour notice.

All the best,

Sarah Hellman
Office Manager

Appointment Date:______________________Time:___________________

736 Chestnut Street, Santa Cruz, CA 95060
Ph: (831) 477.1377 ♦ Fax: (831) 477.0425
www.scnmc.com

SANTA CRUZ NATUROPATHIC MEDICAL CENTER
ACUTE - BIOGRAPHICAL INFORMATION FORM

Date: ____________________

Personal History:

Name: ____ Age: ___________ Gender: __ M __ F

Address: ____
Street and Number City State Zip

Weight: _________ Height: _______ Race: ______________

Date of Birth: ________________ Highest Level of Education: _______________

Primary Phone: ____________________ Secondary Phone: _____________________ Business: ______________________

E-Mail:____

As patient at SCNMC, you will receive our monthly email newsletter informing you of upcoming specials and events. You may choose not to receive this email newsletter by checking here _____.

Present Marital Status: S___ M ___ D___ W___ Domestic Partnership ___ Other_______________________

If married, years married to present spouse? ___________

Current Occupation: ____________________________________ How long? __________ Hrs/Wk ____________

On a scale of 1 to 10, how much do you enjoy your job? _____________

How did you hear about SCNMC or who referred you? ______________________________________

What do you expect from this visit? ____

Insurance Carrier:____

List Yes (Y), No (N), or Past (P) regarding the use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day / Number of years __________

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes / Past: _______________

Soda: Y N P Ounces per day if Yes / Past: ___________________________

Alcohol: Y N P How often & how much if Yes / Past: ____________________________

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P Any Drug Addictions: Y N P Any Drug Treatment: Y N P

Health Concerns:

List in order of importance your primary health concerns: How long have these problems persisted?

1) _______________________________________ _______________________________________

2) _______________________________________ _______________________________________

Under what conditions do your problems usually get worse? Under what conditions do they improve?

1) _______________________________________ _______________________________________

2) _______________________________________ _______________________________________

Medical History

Your primary physician:

Physician's Name: ____

Address: ____ Phone # _____________________

List any major illnesses, hospitalizations and/or operations you have had (include year).

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____

____

When was your most recent physical exam? ____

When was your most recent blood work and by what doctor? ____

Medications

What medications are you currently taking?

Medications	Dosage	For What	How Long

List any supplements you are currently taking:

____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Please list any medication allergies you are aware of:____

Family History

	Father	**Mother**	**Siblings**	**Grandparents**	**Spouse**	**Children**
Age If Living:	______	______	______	___________	______	______
Age when Died:	______	______	______	___________	______	______
Cause of Death	______	______	______	___________	______	______

Family History Cont.

	Father	Mother	Siblings	Grandparents	Spouse	Children
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Dz:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N
Cancer	Y N	Y N	Y N	Y N	Y N	Y N

Symptoms

Circle the behaviors and symptoms that occur to you more often than you would like them to:

aggression	fatigue	sexual difficulties	alcohol dependence	hallucinations
sick often	anger	antisocial behavior	anxiety	avoiding people
chest pain	depression	disorientation	distractibility	worrying
drug dependence	eating disorder	mood elevated	heart palpitations	high blood pressure
hopelessness	impulsivity	irritability	judgment errors	loneliness
memory impairment	mood shifts	panic attacks	phobias/fears	recurring thoughts
sleeping problems	dizziness	suicidal thoughts	thoughts disorganized	trembling

Other (specify): ____

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Any other information you feel is important to share:

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