

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.

Your new patient exam is two hours, and includes an extensive intake and treatment plan. The cost is \$265. 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 48 hour notice for a new patient exam. You will be charged a \$150 cancellation fee for a missed appointment or cancelling with less than 48 hour notice.

All the best,

Sarah Hellman
Office Manager

Appointment Date: _____ Time: _____

736 Chestnut Street, Santa Cruz, CA 95060
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www.scnmc.com

**SANTA CRUZ NATUROPATHIC MEDICAL CENTER
BIOGRAPHICAL INFORMATION FORM - ADULT**

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BIOGRAPHICAL INFORMATION FORM – ADULT**

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? _____

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

Exercise

How often do you exercise? _____

What type of exercise? _____ For How Long? _____

Hobbies: _____

Who referred you? _____

What do you expect from this visit? _____

Are you willing to make lifestyle and diet changes? _____

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Health Concerns:

List in order of importance your primary health concerns:

How long have these problems persisted?

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Under what conditions do your problems usually get worse?

Under what conditions do they improve?

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Medical History

Your primary physician:

Physician's Name: _____

Address: _____ Phone # _____

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

When was your most recent physical exam? _____

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

For Women ----- Date of last Pap Smear _____

Date of last Mammogram _____

Any family history of breast cancer? _____ If yes, whom? _____

Sleep

How many hours per night? _____ If you wake, what is the reason? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

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Diet

Have you gained or lost over ten pounds in the past year? Yes ____ No ____ Gained ____ Lost ____

If yes, was the gain/loss on purpose? Yes ____ No ____

Medications

What medications are you currently taking?

Medications	Dosage	For What	How Long

List any supplements you are currently taking:

Please list any medication or food allergies that you may have: _____

Counseling History

Are you currently receiving counseling? Yes ____ No ____

If yes, please briefly described: _____

Have you received counseling in the past? Yes ____ No ____

If yes, please briefly describe: _____

Please list what are the major stresses in your life:

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age If Living:	_____	_____	_____	_____	_____	_____
Age when Died:	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

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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

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

- | | | | | |
|--------------------------------|----------|-----------|--------------|---------------|
| 1) Life is hopeless. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 2) I am lonely. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 3) No one cares about me. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 4) I am a failure. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 5) People don't like me. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 6) I want to die. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 7) I want to hurt someone. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 8) I am so stupid. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 9) I am going crazy. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 10) I can't concentrate. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 11) I am so depressed. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 12) God is disappointed in me. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 13) I can't be forgiven. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 14) Why am I so different? | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 15) I can't do anything right. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 16) People hear my thoughts. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 17) I have no emotions. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 18) I hear voices in my head. | Never___ | Rarely___ | Sometimes___ | Frequently___ |
| 19) I am out of control. | Never___ | Rarely___ | Sometimes___ | Frequently___ |

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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): _____

Any other information you feel is important to share:

