

# 5 Elements Naturopathic Health Center, LLC

## Patient Profile

5 Elements Naturopathic Health Center, LLC  
850 North Main Street Ext.  
Building 2, Suite 3A  
Wallingford, CT 06492  
Phone: 203-284-1119  
Fax: 203-284-1050  
Website: www.5elementsnhc.com

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Nickname: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone#( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
please circle best contact number Home Work Cell

Address: \_\_\_\_\_

**A note to our patients:** Please complete this questionnaire as thoroughly as possible to aid your physician in his diagnosis and treatment. This is a confidential record of your medical treatment and will not be release, except when you have provided us with written authorization to do so. Thank you.

### PRESENT HEALTH CONCERNS

Please list your most important health concerns in their order or significance.	Prior diagnosis of this problem? If so, What? When? Who?

What goals do you have for your visit at the Health Center today? \_\_\_\_\_

Do you have any questions about our Center or the care that you've chosen today? \_\_\_\_\_

**Patient Profile**

Please list the prescription medications that you are currently taking, with dosages:

1.	2.	3.
4.	5.	6.

Please list the vitamins, minerals, and herbal supplements you are taking, with dosages:

1.	2.	3.
4.	5.	6.

How much coffee, tea, or cola do you drink in one day? \_\_\_\_\_

How much water do you drink on a daily basis? \_\_\_\_\_ How much alcohol? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_ What type? \_\_\_\_\_ How long? \_\_\_\_\_

How long have you been exercising? \_\_\_\_\_ Do you use tobacco? If so, how much? \_\_\_\_\_

Do you follow any particular diet regimens or restrictions? If yes, please describe: \_\_\_\_\_

How often do you shower? \_\_\_\_\_ Brush your teeth? \_\_\_\_\_

**HEALTH SCREENING When was your last?**

blood test? \_\_\_\_\_ cholesterol test? \_\_\_\_\_ flu shot? \_\_\_\_\_

tetanus shot? \_\_\_\_\_ pneumonia vaccine? \_\_\_\_\_ chest x-ray? \_\_\_\_\_

electrocardiogram (EKG/ECG)? \_\_\_\_\_ check for blood in the stool? \_\_\_\_\_

colonoscopy / sigmoidoscopy? \_\_\_\_\_

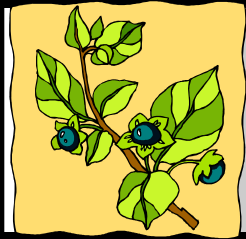
**Men**

prostate exam? \_\_\_\_\_ PSA test? \_\_\_\_\_

**Women**

mammogram? \_\_\_\_\_ Pap smear? \_\_\_\_\_ CA 125 test? \_\_\_\_\_

Relations	Age(s)	Medical Problems
Father		
Mother		
Grandparents		
Aunts, Uncles		
Siblings		
Children		



# 5 Elements Naturopathic Health Center, LLC

## Your Profile

5 Elements Naturopathic Health Center, LLC  
850 N Main Street Ext.  
Building 2, Suite 3A  
Wallingford, CT 06492  
Phone: 203-284-1119  
Fax: 203-284-1050  
WWW.5ELEMENTSNHC.COM

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

Primary Care Physician and location: \_\_\_\_\_

PCP Phone# \_\_\_\_\_ Emergency contact: \_\_\_\_\_

Phone \_\_\_\_\_ Relation: \_\_\_\_\_

Name of Medical Insurance Company: \_\_\_\_\_

active date \_\_\_\_\_ Membership# \_\_\_\_\_

Group# \_\_\_\_\_ Copay \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

Have you every consulted a Naturopathic Physician, an Acupuncturist, or a Nutritionist before? (please circle)

Do you have any environmental allergies (hayfever, cats, dogs,...)? What are they?

\_\_\_\_\_

Do you have any life threatening allergies (penicillin, beestings, peanuts, shellfish,...)? What are they?

\_\_\_\_\_

Have you ever been diagnosed with a condition(s) which you still have today? If so, what are they?

\_\_\_\_\_

What immunizations (childhood, flu, HepB) have you had? When?

\_\_\_\_\_

Childhood illnesses (cholic, ear infections, bronchitis, chicken pox, mono, asthma, rashes, freq sore throats, ect...)?

\_\_\_\_\_

---

---

**5 Elements**  
**NATUROPATHIC HEALTH CENTER, LLC**

---

---

**Your Office Visit**

Dear Patient,

Welcome to 5 Elements Naturopathic Health Center, LLC. We are pleased you have chosen to pursue a Naturopathic Medical Approach to taking care of your health. This natural approach to health can be used as a supportive alternative to conventional medical care or as your primary care choice. Please be advised that, in the State of Connecticut, Naturopathic Physicians are considered specialists and can not prescribe your medications. This law approximately 100 years old and is unique to Connecticut. In other states, Naturopaths are considered primary care doctors and have prescriptive authority. Luckily, the need for a Naturopathic Physician to prescribe is very rare. In that rare instance, you may be referred back to your primary care doctor or to another specialist.

Your visit with the Naturopathic Physician will be from 30-60 minutes long. Unlike most medical experiences, your Naturopath realizes that you have important knowledge about your condition that he would like you to share. He also realizes that your mental and emotional well-being are as important as your physical health. You may be asked to make some lifestyle changes to affect your health. It is important that you ask questions so that you understand why you are being asked to change either your diet or lifestyle. **You are the most important part of the healthcare team!**

Please understand that because you are scheduled for up to a 30-60 minute appointment, there are a small number of appointments available. If you miss your appointment or cancel at the last moment, someone else who needed help could have had your time. Because of this situation our office **requires a cancellation 24 hours before your appointment.** We do understand that emergencies arise and that weather in our area is unpredictable. We will therefore make appropriate exceptions and excuse the first last minute cancellation. **Any last minute cancellation or no show after the first will be billed to you at the standard rate of service.** Thank you very much for your understanding in this matter and your assistance with our trying to help others.

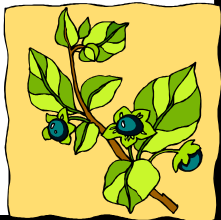
We look forward to helping you achieve your health goals!

I \_\_\_\_\_, read and understand the above policies.

---

Signature

Date



# 5 Elements Naturopathic Health Center, LLC

## Patient Insurance Authorization Form

5 Elements Naturopathic Health Center, LLC  
850 N. Main Street Ext  
Building 2, Suite 3B  
Wallingford, CT 06492  
Phone: 203-284-1119  
Fax: 203-284-1050  
www.5elementsnhc.com

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I hereby authorize payment of medical expenses by \_\_\_\_\_ insurance company to 5 Elements Naturopathic Health Center, LLC. These expenses will not exceed my indebtedness to this medical office and I have agreed to pay, at time of service, any balance or professional service charges which represent deductibles, co-pays, or uncovered services. I understand that I am responsible for payment of charges from medical treatment if they are not covered by insurance.

\_\_\_\_\_  
Patient's signature or legal representative (if minor) Printed name

\_\_\_\_\_  
Today's date

# 5 Elements Naturopathic Health Center, LLC

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Review of Systems: Do you currently have any of these symptoms?**

<p><b>•Constitutional Symptoms</b></p> <input type="checkbox"/> Fever/ Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight change <input type="checkbox"/> Fatigue/weakness <p><b>•Cardiovascular</b></p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beat/Palpitations <input type="checkbox"/> Varicose veins <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Poor circulation Swelling in extremities/edema <p><b>•Respiratory</b></p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing blood or mucus <input type="checkbox"/> Difficulty breathing laying down <input type="checkbox"/> Chest pain with breathing <input type="checkbox"/> wheezing <p><b>•Gastrointestinal</b></p> <input type="checkbox"/> Hemorrhoids           Mucus in stool <input type="checkbox"/> Blood in stool        Floating stool <input type="checkbox"/> Black colored stool <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Hernia <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Nausea/vomiting/diarrhea <input type="checkbox"/> anal discomfort <input type="checkbox"/> Constipation <input type="checkbox"/> Undigested food in stool (besides corn) <input type="checkbox"/> Abdominal mass or lumps <input type="checkbox"/> Heartburn <input type="checkbox"/> Bloating <input type="checkbox"/> Poor appetite	<p><b>•Genito-Urinary</b></p> <input type="checkbox"/> Any burning of urination <input type="checkbox"/> Testicular pain <input type="checkbox"/> Difficulty starting/ending urine stream <input type="checkbox"/> Poor control of bladder <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Any type of sexual dysfunction <input type="checkbox"/> Inability to obtain or maintain erection <input type="checkbox"/> Difficulty with orgasm <input type="checkbox"/> Urination at night <p><b>•Endocrine</b></p> <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Premenstrual irritability/breast tender. <input type="checkbox"/> Menopause <input type="checkbox"/> Loss of body hair <input type="checkbox"/> Dry skin <input type="checkbox"/> Excessive thirst Irregular menses <p><b>•Skin, mouth, and breast</b></p> <input type="checkbox"/> Discharge from nipples <input type="checkbox"/> Hair or nail changes <input type="checkbox"/> Itching <input type="checkbox"/> Sores <input type="checkbox"/> Acne <input type="checkbox"/> Rash <input type="checkbox"/> Lumps	<p><b>•Hematologic lymphatic</b></p> <input type="checkbox"/> Easy bruising <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Bleeding gums <p><b>•Allergic / Immunologic</b></p> <input type="checkbox"/> Body Rash <input type="checkbox"/> Runny nose <input type="checkbox"/> Sneezing <input type="checkbox"/> Wheezing <p><b>Musculo-skeletal</b></p> <input type="checkbox"/> Swelling <input type="checkbox"/> Masses <input type="checkbox"/> Neck pain <input type="checkbox"/> Neck spasm <input type="checkbox"/> Cramps <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Abnormal arm or leg feelings <input type="checkbox"/> Loss of muscle bulk <input type="checkbox"/> Arm or leg weakness <input type="checkbox"/> Back pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Loss of control of arms or legs <input type="checkbox"/> Poor coordination <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Hand or foot pain	<p><b>•Neurological</b></p> <input type="checkbox"/> Poor vision <input type="checkbox"/> Blurry vision <input type="checkbox"/> Double vision <input type="checkbox"/> Loss of hearing (one or both) <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Numbness in face <input type="checkbox"/> Passing out/unconscious <input type="checkbox"/> Headache <input type="checkbox"/> Droopy face or eye <input type="checkbox"/> Eye pain <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness <input type="checkbox"/> Slurred speech <input type="checkbox"/> Difficulty speaking <p><b>•Psychiatric</b></p> <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Depression <input type="checkbox"/> Mania <input type="checkbox"/> Disorientation <input type="checkbox"/> Euphoria <input type="checkbox"/> Anxiety <input type="checkbox"/> Hallucination <input type="checkbox"/> Insomnia Memory loss that you remember
---	--	--	---

**Please check any problems you have (unless described earlier). C= current P= past**

- |                          |                                  |                        |                      |
|--------------------------|----------------------------------|------------------------|----------------------|
| ___ Alcoholism/Addiction | ___ Diabetes                     | ___ Multiple Sclerosis | ___ Blood Clots      |
| ___ Anemia               | ___ Emphysema, bronchitis        | ___ Pneumonia          | ___ Pacemaker        |
| ___ Arthritis            | ___ Glaucoma                     | ___ Psychiatric Care   | ___ Tuberculosis     |
| ___ AIDS                 | ___ Hepatitis A B C              | ___ Stroke ___ Cancer  | ___ Thyroid problems |
| ___ Bleeding Disorders   | ___ Sexually Transmitted Disease | ___ Jaundice           |                      |

**Thank you for your time and attention to this questionnaire, it is important that we are thorough in obtaining your medical history. It is also a requirement of your medical insurance company.**