The Center for Natural Health, LLC

at

ElixirSpa

163 Main Street, Westport, CT 06880
Phone: (203) 227-1826

Salvatore Fiorentino, ND, MS

Patient Information:

(Please Print)

Name: _____ Date of Birth: _____ Age: ____ Gender: M F

Address (Street): _____

City: _____ State: _____ Zip Code: _____

Phone (h): _____ (c): _____ (w): _____

Preferred Method of Contact: _____

SS#: _____ Occupation: _____

Name of Employer: _____ Employer's Address: _____

Email Address: _____

Marital/Relationship Status: _____

If Minor, Name of Parent/Guardian: _____

Children/Dependents: _____

Emergency Contact (Name): _____

Relationship to you: _____

Phone (h): _____ (c): _____ (w): _____

Primary Care Physician (Name & Phone): _____

How did you hear about The Center For Natural Health, LLC? _____

_____

Name of Insurance Co.: _____

I authorize The Center For Natural Health, LLC to call and leave a message on the following:

Home Phone: _____ Leave a message on this line: Yes No

Cell Phone: _____ Leave a message on this line: Yes No

Office Phone: _____ Leave a message on this line: Yes No

Signature: _____ Print:_____ Date: _____

PERSONAL MEDICAL HISTORY

Name: _____ Date: _____

List your **chief** (**main**) **complaint**: _____

_____

To help us evaluate you better, please place a check mark next to all the symptoms that you currently (**now**) are experiencing, and/or those that have occurred in the **past**. If only part of the symptoms apply, circle that particular symptom(s).

NOW	PAST	GENERAL SYMPTOMS
		tired, weak, lack of energy
		depression, melancholy, moodiness
		worry, anxiety, nervousness, irritability
		sleeplessness or sleep too much
		frequent colds or other illness
		headaches
		don't sweat enough
		sweat too much
		night sweats
		dizziness, fainting, convulsions
		loss or gain of weight
		other:

NOW	PAST	SKIN & HAIR
		acne or pimples
		skin rashes
		hives
		stretch marks
		skin ulcers or Sores
		dryness roughness or scaling skin, scalp, elbows, knees, feet, around nose, ears, eyebrows, etc.
		hair loss or thinning
		dry, coarse hair or split ends
		bruise easily
		nails weak, ridged or split easily
		brown spots or bronzing on skin
		moles, warts or skin tags
		sunburn easily
		cuts heal slowly or scar badly
		flush easily
		hands or numb feet or tingling
		feet burn, athletes foot
		other:

NOW	PAST	EYES
		near or farsightedness
		blurred or failing vision
		dry, burning or itching eyes
		eyes water excessively
		eyes sensitive to light
		night blindness
		bloodshot or puffy eyes
		other:

NOW	PAST	EARS
		earaches
		noises or ringing in ears
		ear discharges
		loss of hearing
		lots of wax
		other:

NOW	PAST	NOSE & THROAT
		hay fever, sinusitis, runny, nose
		nosebleeds
		cracks in corners of mouth
		dry or chapped lips
		sore throats or tonsillitis
		clear throat often
		sore, red or cracked tongue
		cold sores or herpes
		inability to smell or taste
		lots of cavities
		bleeding gums
		hoarseness
		other:

NOW	PAST	RESPIRATORY
		cough frequently
		spitting up mucus or blood
		difficulty breathing
		shortness of breath on exertion
		chest pain
		other:

NOW	PAST	GASTROINTESTINAL
		loss of appetite
		gagging, difficulty swallowing
		nausea or vomiting
		bad breath
		metallic or bitter taste in mouth
		food cravings
		can't eat fats
		heartburn
		indigestion
		heaviness after eating
		belching or gas
		bloating
		stomach or abdomen tender/pain
		symptoms relieved by eating
		symptoms worse by eating
		avoid certain foods
		diarrhea or loose stool
		constipation
		change in bowel movements
		light colored or greasy stool
		dark stools or blood in stool
		feeling of incomplete evacuation
		undigested food in stool
		foul odor of stool or gas
		hemorrhoids
		headache, dizziness or irritability when meal skipped

NOW	PAST	MALE
		prostate problems
		difficulty or unusual urination
		discomfort or pain in genital area
		difficultymaintaining an erection

NOW	PAST	MALE
		diminished sexual desire
		excessive sexual desire
		other:

NOW	PAST	MUSCULO-SKELETAL
		muscle pain or stiffness
		swollen, painful or stiff joints
		bone pains
		painful feet, ankles or calves
		tremors or twitches
		loss of strength
		hernia
		muscle wasting
		other:

NOW	PAST	CARDIOVASCULAR
		heart beats fast or irregularly
		tightness in chest
		discomfort at high altitude
		dizzy or weak upon standing
		swollen feet, ankles or legs
		cold hands or feet
		hands or feet turn blue
		blue fingernails
		leg pain when walking
		varicose veins
		tendency to anemia
		high blood pressure
		low blood pressure
		other:

NOW	PAST	URINARY
		difficulty urinating
		urinate frequently at night
		bedwetting
		incomplete urination
		pain when urinating
		bladder infections
		kidney infections
		kidney stones
		lower back pain
		other:

NOW	PAST	FEMALE
		irregular menstruation
		pain prior to or with periods
		depressed, tense, or irritable around periods
		painful or swollen breasts
		lumps in breasts
		discharge from breasts
		symptoms occur in a monthly pattern
		pain, discomfort or itching in genital area
		other:

NOW	PAST	FEMALE
		hot flashes
		diminished sexual desire
		excessive sexual desire
		difficulty having orgasm
		inability to conceive
		number of pregnancies
		number of children
		miscarriages or abortions
		vaginal discharge

Please proceed to the next page →

1. **When was your last known period/menses: _____.**

2. **How many days does it usually last: _____.**

3. **What is the total length of your cycle: _____.**

4. **Are you currently pregnant? _____.** 5. **Number of pregnancies: _____.**

6. **Number of children: _____.** 6. **Date of last PAP Smear? _____.**

7. **Have you ever had an abnormal PAP Smear? _____.**

8. **Do you use birth control? _____.** 9**. If so, what type of birth control? _____.**

10. **For how long have you used birth control (if applicable)? _____.**

11. **Please give an example of what you eat and drink on a typical day:**

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Beverage: _____

12. **Do you exercise? _____** 13. **How many days per week? _____**

14. **Do you lift weights? _____** 15. **Do you run? Jog? Walk? _____**

16. **For how long do you exercise each day? _____**

20. **Do you have any known allergies?**

Medications (please list all)? _____

_____.

Foods: _____

_____.

Other: _____

_____.

21. **Do you use any of the following? Y (Yes) or N (No)**

_____ Cigarettes/Tobacco _____ Pack per week

_____ Coffee or Black Tea _____ Cups per day

_____ Alcohol _____ Times per day

_____ Marijuana _____ Times per day

22. Please list if you take any of the following:

Prescription Medication:

_____
_____
_____
_____
_____
_____
_____

Vitamins and Mineral:

_____
_____
_____
_____
_____
_____
_____

Over –The – Counter Medications:

_____
_____
_____
_____
_____
_____
_____

Botanicals / Herbs:

_____
_____
_____
_____
_____
_____
_____

23. **Have you ever had any vaccinations?** _____

24. **Have you had the Hepatitis B vaccinations?** _____. **If so, When?** _____

24. **Please list if you ever been hospitalized, had any surgeries, serious illnesses, accidents:**
List Dates, and What or How it occurred (if applicable):

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Has a blood relative ever had any of the following?

	Which relative(s)?	***Details:***
Autoimmune Disorder Ex. MS, Lupus, Arthritis etc.		
Stroke		
Epilepsy		
Migraines		
Thyroid Disease		
Cancer		
Hepatitis		
Tuberculosis		
Diabetes		
Heart Disease		
High Blood Pressure		
Gallbladder Disease		
Allergies/Hay Fever		
Asthma		
Kidney Disease		
Mental Illness		
Suicide		
Osteoporosis		
Alcoholism/Addition		