MorningStar *Family Health Center*

New Patient Information Form

Last Name: _____ First Name:_____ MI:_____

Street: _____ P.O. Box _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

DOB: _____ Gender: Male: _____ Female: _____

Marital Status: Single:____ Married: _____ Widowed: _____ Divorced: _____

Email: _____

Pharmacy: _____

How would you like to be contacted to confirm appointments:

Text: _____ Email: _____ Phone: _____

Emergency Contact

Last Name: _____ First Name: _____

Home Phone: _____Cell Phone: _____

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MorningStar
Family Health Center

Initial Consultation

Name: _____ Date: _____

Main Complaints:

1)_____ 2)_____

3)_____ 4)_____

How long have you suffered with this problem? _____

Any other complaints: _____

_____

Would you like improvement with any of the following?:

☐ Digestion: Reflux, Gas, Constipation
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well Being
☐ Energy

What have you tried doing to resolve this problem that Did Not work?

_____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at it's worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

_____

What effect does this have on your body functions? _____

_____

Are you here visiting us to:

a) Resolve my immediate problem
b) Life style program for optimized living
c) Both
d) Other: _____

How have you taken care of your health in the past?

Medications	Holistic
Routine medical	Vitamins
Exercise	Chiropractic
Diet and Nutrition	Other: _____

How did the previous methods work for you? _____

_____

What are you afraid this might be or will be affecting without change? Please circle

Job	Freedom
Kids	Future abilities
Marriage	Finances
Sleep	Time

Are there any health conditions you are afraid this might turn into?

Diminished Future abilities	Surgery
Stress	Arthritis
Weight gain	Cancer
Heart disease	Diabetes
Depression	Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific _____

_____

_____

What would be different or better without this problem? Please circle:

Diminished stress	Sleep
More energy	Work
Self esteem	Outlook
Confidence	Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Last Name First Name M.I. Prefix/Suffix Date of Birth

MEDICAL CONDITIONS: Please circle or list any medical conditions you have: (i.e.: Diabetes, High Blood Pressure, Heart Disease, Migraines, Kidney Problems, Cancer, Arthritis, etc) Please provide dates began, if known, and any comments about the condition. If you see a specialist for it, please list name

MEDICAL CONDITION	DATE DIAGNOSED	COMMENTS (and specialist name if applicable)

SURGICAL HISTORY: Please list all surgeries/operations you have had: (i.e.; appendectomy, tonsillectomy, gall bladder removal, hysterectomy, knee replacements, etc.) Include dates, hospital, and surgeon if known.

DATE	SURGERY	HOSPITAL	SURGEON

OTHER HOSPITALIZATIONS: Please list any other overnight hospital stays you have had: (i.e.: childbirth, pneumonia, psychiatric hospitalizations, etc.) Include reason for admission, dates, and hospital, if known.

DATE	REASON FOR ADMISSION	HOSPITAL

MEDICATIONS: Please list all medications that you take. Please include prescription drugs, OTC medications, vitamins, and supplements. Also include medication dose, number of pills taken, and how often:

MEDICATION	STRENGTH	NUMBER OF PILLS	HOW OFTEN

ALLERGIES: Please list allergies to medications, foods, and other substances. Please indicate what your reaction was. (i.e.; Penicillin →Hives, Cats→Wheezing)

MEDICATION/SUBSTANCE	REACTION

DIET: Please describe your usual dietary intake:

Starchy Foods (pasta, breads, potatoes)	___ high	___ medium	___ low	___ none
Sweets (candy, pastries, doughnuts)	___ high	___ medium	___ low	___ none
Fatty Foods (bacon, sausage, fried foods)	___ high	___ medium	___ low	___ none
Fruits	___ high	___ medium	___ low	___ none
Vegetables	___ high	___ medium	___ low	___ none
Dairy (milk, cheese, yogurt)	___ high	___ medium	___ low	___ none
Lean Meats (fish, chicken)	___ high	___ medium	___ low	___ none

Are there any foods you do not tolerate, or try to avoid? (i.e.: gluten, lactose, etc.)

_____

Are you currently trying to lose weight, or are you considering it? ___ no __ yes (currently)
__ yes (considering)

EXERCISE:

Do you exercise regularly? __ Yes __ No

If so, what type and how often? _____

WORK:

Are you currently working/going to school? Please circle:

Yes, Full Time ◆ Yes, Part Time ◆ No, Retired ◆ No, Unemployed ◆ No, Disabled ◆ No, other:

Please describe current occupation/vocation: (Where and what you do)

Are you now, or have you in the past been exposed to hazards? (i.e.: asbestos, toxic chemicals, fumes, radiation, etc.)

__ No __Yes (past) __Yes (currently) If Yes, Please describe what and when:

MILITARY SERVICE:

Have you ever served in the military? __ No __ Yes, in past __ Yes, currently

If so, THANK YOU FOR YOUR SERVICE. Please describe service (branch, time in service, foreign posts, combat or other injuries and disabilities):

SOCIAL HISTORY:

TOBACCO:

Cigarettes: ___never smoked
___quit (please list packs per day, how many years, and date you quit) _____
___currently smoking (please list packs per day and when you started) _____

Cigars: ___never smoked
___quit (please list cigars per day or week, how many years, and date you quit) _____
___currently smoking (please list cigars per day or week and when you started) _____

Pipe: ___never smoked
___quit (please list how many years, and date you quit) _____
___currently smoking (please list times per day and when you started) _____

Chew: ___never used
___quit (please list cans per day, how many years, and date you quit) _____
___currently chewing (please list cans per day and when you started) _____

ALCOHOL: Please describe your alcohol use: (one drink= 12 oz. beer, 4 oz. wine, or 1 shot liquor)

___never drank
___quit drinking alcohol (please list drinks per day and date you quit) _____
___currently drink alcohol

very rarely	occasionally	socially		regularly		(circle)
Number of drinks_____		per day	week	month	year	(circle)

Are you or anyone close to you concerned about how much you drink? ___ No ___ Yes

DRUGS: (Please describe your use of mind altering drugs, including type [marijuana, cocaine, pills not prescribed to you, ecstasy, etc.] and how much, and provide details.) ***Please be honest. We ask for medical reasons. This is confidential.***

___never used
___quit (please list types of drugs, how many years, and when you quit)

___currently using (please list types of drugs, when you started, and how often you use)

Are you or anyone close to you concerned about your drug use? ___ No ___ Yes

CAFFEINE: (Please describe how much caffeine you consume, including coffee, tea, sodas, etc.)

Coffee:	_____ cups	per	day	week	(circle)
Tea:	_____ cups	per	day	week	(circle)
Soda:	_____ cans/btls	per	day	week	(circle)
Energy Drinks:	_____ cans/shots	per	day	week	(circle)

RELATIONSHIP HISTORY:

Please describe current status: (circle) single married committed relationship divorced separated widowed

Sexual Activity: (circle) currently active never active not currently active

If sexually active, do you use birth control? If so, method: _____

Do you feel safe in your current relationship? yes no N/A

FAMILY HISTORY: Please complete to the best of your ability.

RELATIONSHIP	M or F	living?	year of birth	MEDICAL PROBLEMS	AGE OF DEATH	CAUSE OF DEATH (IF APPLICABLE)
MOTHER	F					
FATHER	M					
Mat. GM	F					
Mat. GF	M					
Pat. GM	F					
Pat. GF	M					
SIBLINGS:						

CHILDREN

OTHER SIGNIFICANT FAMILY HISTORY

REVIEW OF SYSTEMS: Please circle any problems or symptoms you are having.

GENERAL: fever ◆ chills ◆ fatigue ◆ weight loss ◆ weight gain ◆ other:

EYES: blurred vision ◆ double vision ◆ watery eyes ◆ blindness ◆ eye pain ◆ other:

EARS: decreased hearing ◆ clogged ears ◆ ear pain ◆ ringing ◆ dizziness ◆ ear discharge ◆ other:
NOSE/SINUS: runny nose ◆ sinus congestion ◆ sinus pain ◆ bloody nose ◆ sneezing ◆ other:
MOUTH: dental problems ◆ cold sores ◆ tongue problems ◆ mouth/jaw pain ◆ other:
THROAT: sore throat ◆ post nasa drip ◆ painful swallowing ◆ burning in throat ◆ enlarged tonsils ◆ other:

RESPIRATORY: shortness of breath ◆ wheezing ◆ coughing ◆ asthma ◆ COPD ◆ other:

CARDIOVASCULAR: chest pain ◆ heart failure ◆ palpitations ◆ heart murmur ◆ aneurysms
high blood pressure ◆ lightheadedness ◆ swollen ankles ◆ cold hands and feet
leg cramping with walking ◆ anemia ◆ varicose veins ◆ other:

DIGESTIVE: decreased appetite ◆ difficulty swallowing ◆ heartburn ◆ stomach upset ◆ abdominal pain
nausea ◆ vomiting ◆ diarrhea ◆ constipation ◆ bloody bowel movements ◆ black bowel movements
hemorrhoids ◆ liver problems ◆ jaundice ◆ other:

KIDNEY: frequent urination ◆ painful urination ◆ blood in urine ◆ kidney stones ◆ kidney failure
difficulty passing urine ◆ waking at night to urinate often ◆ other:

GENITAL (WOMEN): painful periods ◆ heavy periods ◆ irregular periods ◆ painful intercourse
sexual difficulties ◆ vaginal dryness ◆ ovarian cysts ◆ fibroids ◆ difficulty getting pregnant ◆ PMS
endometriosis ◆ breast pain ◆ breast lumps ◆ nipple discharge ◆ other:

GENITAL (MEN): lump in testicles/scrotum ◆ pain in testicles/scrotum ◆ sexual difficulties
prostate problems ◆ difficulty with fertility ◆ other:

ENDOCRINE/GLANDS: intolerance to heat ◆ intolerance to cold ◆ thyroid problems
adrenal gland problems ◆ menopause issues ◆ ow testosterone ◆ hair loss ◆ other:

SKIN: moles ◆ acne ◆ skin lumps/bumps ◆ eczema ◆ psoriasis ◆ skin cancers ◆ dry skin ◆ oily skin
rash ◆ nail problems ◆ hair problems ◆ itching ◆ other:

MUSCULOSKELETAL: back pain ◆ neck pain ◆ shoulder pain ◆ elbow pain ◆ wrist pain ◆ hand pain
hip pain ◆ knee pain ◆ ankle pain ◆ foot pain ◆ arthritis ◆ muscle pain ◆ gout ◆ other:

IMMUNE SYSTEM: frequent illness ◆ allergies ◆ swollen glands ◆ autoimmune disease ◆ HIV
rheumatoid arthritis ◆ Lyme Disease ◆ other:

NEUROLOGIC: headaches ◆ passing out ◆ stroke ◆ memory problems ◆ seizures ◆ confusion
muscle weakness ◆ lack of coordination ◆ difficulty walking ◆ decreased sensation ◆ tremors
attention problems ◆ nerve pain ◆ other:

PSYCHOLOGICAL: anxiety ◆ depression ◆ obsessive/compulsive disorder ◆ mania ◆ insomnia
stress ◆ sadness ◆ seasonal affective disorder ◆ suicidal thoughts ◆ other: