Nucare Integrative Health Center

CONFIDENTIAL PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____

State: _____Zip: _____ Home Phone: _____ Cell Phone: _____

How many children? _____ Primary Doctor: _____

Occupation: _____ Employer Name? _____

City: _____ Office Phone: _____

Spouse's Name: _____ Referred By? _____

Email: _____

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑Work Email

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Briefly list your main health problems:

_____

_____

_____

What medications are you currently taking and for what condition: _____

_____

_____

_____

What vitamins, minerals, or herbs do you currently take? _____

_____

_____

_____

List any known allergies:

_____

_____

_____

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Habits	**None**	**Light**	**Moderate**	**Heavy**
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

Family History
Family Members- Present and past health conditions (Ex. Heart disease, cancer, arthritis…etc)

Have you ever suffered from: (please circle)

Alcoholism	Diabetes	Loss of smell
Allergies	Digestion problems	Loss of taste
Anemia	Dizziness	Muscle aches/Stiffness
Anxiety	Ears Ringing	Neck pain
Arteriosclerosis	Heavy menses	Numbness
Arthritis	Fatigue/Low Energy	Pacemaker
Asthma	Fibroids	Polio
Back pain	Fibromyalgia	Prostate Trouble
Bronchitis	Frequent urine	Scoliosis
Cancer	Hashimoto's	Sciatica
Chest pain	Headaches	Sinus infection
Cold Extremities	High Blood Pres.	Sleep- going to
Constipation	Hot Flashes	Sleep- staying
Cramps	Irreg. heart beat	Stress
Cystic Breasts	Kidney stones	Stroke
Depression	Loss of memory	Swelling of ankles
	Loss of Balance	Thyroid condition
		Other_____

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What surgeries have you had? When?

_____
_____
_____

Do you currently smoke tobacco of any kind?❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoke ❑ Current sometimes smoker

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____
_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No

If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0% ❑ Yes ❑No

If yes, other comments regarding Diabetes: _____

For women only:

Are You or Could You be Pregnant? _____

Patient's Signature _____ Date _____

Parent/Guardian Signature if Patient is a Minor _____ Date _____