DR. ANGELA AGRIOS, ND

Palisades Natural Medicine

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Patient Information

Name	DOB	Gender M F
	Email	

Address	Home Phone
	Mobile Phone

Emergency Contact

Name Relationship to you Phone

Have you seen a doctor that practices natural or integrative medicine before? Y/N
If so, what type of natural medicine oriented clinicians have you visited?

___Naturopathic Doctor ___Holistic MD/DO ___Acupuncturist ___Chiropractor ___Other:

How did you find us?
___Doctor Referral ___Patient Referral ___web search ___YouTube Video

If you were referred, please let us know by whom:

Do you have questions about Naturopathic Medicine?

What are your health goals?

Do you have health insurance? Y/N
If Yes, HMO or PPO? Who is your insurance carrier?

Please list other heath care providers you are currently working with:

Name	Specialty	Contact Info
1.		
2.		
3.		
4.		

Current Health Concerns

Please list by order of importance to you. (Attach another list if necessary)	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe:
1.		
2.		
3.		
4.		
5.		
6.		

Personal & Family Health History

Date of last physical exam?	Date of last Dexa Scan (bone density scan)?
Date of most recent blood work?	Date of last colonoscopy?
Mother: ❑ Living ❑ Deceased Age: Cause if deceased:	Sibling: Y/N Number living: Number deceased: Gender: Age(s): Cause(s) if deceased: 1. 2. 3. 4.
Father: ❑ Living ❑ Deceased Age: Cause if deceased:	

Personal & Family Diagnosed Health Conditions	YES	Who? Indicate self or a specific family member	Notes:
ADD/ADHD	❑		
Alcohol/drug addiction	❑		
Anemia	❑		
Alzheimer's/Dementia	❑		
Arthritis (Osteo or Rheumatoid?)	❑		
Asthma	❑		
Autoimmune diseases	❑		
Birth defects	❑		
Blood disorder	❑		
Cancer	❑		What kind? Age diagnosed?
Cardiovascular Disease	❑		
Depression	❑		
Diabetes Type 2	❑		
Diverticulosis	❑		
Eating Disorder	❑		
Eczema	❑		
Epilepsy/Seizure Disorder	❑		
Fibromyalgia	❑		
Gallstones/Gall Bladder Disease	❑		
Gout	❑		
High Cholesterol	❑		
HIV/Aids	❑		
Hypertension	❑		
Inflammatory Bowel Disease	❑		
Kidney Disease	❑		
Learning Disability	❑		
Liver Disease - If Y, specify:	❑		
Mental illness – If Y, specify:	❑		
Neurologic disorder	❑		
Osteopenia/Osteoporosis	❑		
Stomach or Duodenal Ulcers	❑		
Stroke	❑		
Thyroid disease	❑		
Other:	❑		

Review Of Systems – Check/Circle appropriate responses below

Neuro-Endocrine:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
"Brain Fog"/ Memory difficulty	❑	❑	1 2 3	
Depression	❑	❑	1 2 3	
Irritability	❑	❑	1 2 3	
Anxiety	❑	❑	1 2 3	
Panic Attacks	❑	❑	1 2 3	
Poor stamina	❑	❑	1 2 3	
Fatigue	❑	❑	1 2 3	Recent onset or Chronic?
Sensitive to light	❑	❑	1 2 3	
Sensitive to smells	❑	❑	1 2 3	
Vertigo/dizziness	❑	❑	1 2 3	
Fainting	❑	❑	1 2 3	
Seizures	❑	❑	1 2 3	
Thirst ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Appetite ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Hypoglycemia - need to eat often or feel weak, irritable shaky	❑	❑	1 2 3	
Weight ❑ Gain ❑ Loss	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	How much did you weigh last yr? 5 years ago? 10 years ago? What is your ideal weight?
Energy				Rate from 1-10 Best time of day? Hardest time of day? Consistent all day?
Sweat ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Body Temp ❑ Cold ❑ Hot	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	

Head:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Hair	❑	❑		❑ Dry ❑ Thinning ❑ Excessive shedding ❑ Balding - Where? ❑Alopecia ❑Male Pattern ❑Other:
Headaches	❑	❑	1 2 3	Location of pain? Sensation of pain?
Migraines	❑	❑	1 2 3	
Eyes:				
Dryness	❑	❑	1 2 3	
Tearing	❑	❑	1 2 3	
Cataract (s)	❑	❑	1 2 3	
Glaucoma	❑	❑	1 2 3	
Vision	❑	❑		❑ Near sighted ❑ Far sighted Change in vision?
Under eye bags /dark circles	❑	❑	1 2 3	
Ears:				
Ear infections	❑	❑	1 2 3	
Excessive ear wax build-up	❑	❑	1 2 3	
Tinnitus	❑	❑	1 2 3	
Nose:				
Nasal congestion	❑	❑	1 2 3	
Nasal dryness	❑	❑	1 2 3	
Nose runs	❑	❑	1 2 3	
Nose bleeds	❑	❑	1 2 3	
Post-nasal drip	❑	❑	1 2 3	
Sinus pressure	❑	❑	1 2 3	
Sinus infections	❑	❑	1 2 3	
Mouth/Throat:				
Canker sores/ Oral lesions	❑	❑	1 2 3	
Periodontal disease	❑	❑	1 2 3	
Amalgam fillings	❑	❑	1 2 3	How many?
Hoarse voice	❑	❑	1 2 3	

Cardiovascular:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Shortness of breath	❑	❑	1 2 3	
High blood pressure	❑	❑	1 2 3	
Low blood pressure	❑	❑	1 2 3	
Chest pain	❑	❑	1 2 3	
Palpitations/ ”flutters”	❑	❑	1 2 3	
Heart rhythm abnormalities	❑	❑	1 2 3	
Murmur	❑	❑	1 2 3	
Poor circulation: cold hands/feet	❑	❑	1 2 3	
Varicose veins	❑	❑	1 2 3	
Leg cramps	❑	❑	1 2 3	
Loss of hair on lower limbs	❑	❑	1 2 3	
Respiratory:				
Cough	❑	❑	1 2 3	
Wheezing	❑	❑	1 2 3	
Bronchitis	❑	❑	1 2 3	
Pneumonia	❑	❑	1 2 3	
Positive TB test	❑	❑	1 2 3	
Immune system:				
Frequent colds/flus	❑	❑	1 2 3	
Long recovery time from illness	❑	❑	1 2 3	
Frequent antibiotic use	❑	❑	1 2 3	
Chronic inflammation	❑	❑	1 2 3	
Chronic viral infections (EBV, CMV, HIV)	❑	❑		
Swollen glands	❑	❑	1 2 3	
Night sweats	❑	❑	1 2 3	
Gastro-Intestinal:				
Acid reflux/ heartburn	❑	❑	1 2 3	
Abdominal pain	❑	❑	1 2 3	

Gastro-Intestinal: ***continued***	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
Ulcer(s)	❑	❑	1 2 3	
Intestinal cramping	❑	❑	1 2 3	
Abdominal bloating	❑	❑	1 2 3	
Belching	❑	❑	1 2 3	
Nausea	❑	❑	1 2 3	
Vomiting	❑	❑	1 2 3	
Bowel Movements Constipation Diarrhea Blood or mucus	 ❑ ❑ ❑	 ❑ ❑ ❑	 1 2 3 1 2 3 1 2 3	Frequency: ❑ Multiple BMs daily ❑ 1x per day ❑ Every other day ❑ Other: Consistency: ❑Loose ❑Soft ❑ Formed ❑Hard ❑Pellets ❑ Other:
Flatulence	❑	❑	1 2 3	
Itching anus	❑	❑	1 2 3	
Rectal pain/ bleeding	❑	❑	1 2 3	
Hemorrhoids	❑	❑	1 2 3	
Fissures	❑	❑	1 2 3	
Genito-Urinary:				
Frequent urination	❑	❑	1 2 3	❑ Day ❑ Night
Urinary incontinence	❑	❑	1 2 3	❑ Day ❑ Night
Blood in urine	❑	❑	1 2 3	How long?
Urinary tract infections	❑	❑	1 2 3	
Change in libido	❑	❑	1 2 3	❑ Increased ❑ Decreased
Sexually active	❑	❑		If Y, frequency of sexual activity? Number of partners in the last year? Satisfied with your sex life? Y/N
Sexually transmitted infections	❑	❑		❑ HIV ❑ Herpes ❑ HPV/Warts ❑ Gonorrhea ❑ Chlamydia ❑ Syphilis ❑ Hepatitis
Birth control/ barrier method used?	❑	❑		If yes, what type(s)
Impaired fertility? Y/N	❑	❑		

Musculoskeletal:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Joint Pain	❑	❑	1 2 3	Where?
Muscle Weakness	❑	❑	1 2 3	
Pain	❑	❑		
Skin:				Quality: Dry Oily Normal Thin
Bruise easily	❑	❑	1 2 3	
Hives	❑	❑	1 2 3	
Rashes	❑	❑	1 2 3	
Frequent fungal infections	❑	❑	1 2 3	
Bumpy skin	❑	❑	1 2 3	
Flaky scalp	❑	❑	1 2 3	
Psoriasis	❑	❑	1 2 3	
Eczema	❑	❑	1 2 3	
Acne	❑	❑	1 2 3	
Precancerous/ cancerous growths	❑	❑	1 2 3	
Moles	❑	❑	1 2 3	
Warts	❑	❑	1 2 3	
Female Health:				
Vaginal symptoms:				Date of last gynecologic exam:
Itchiness	❑	❑	1 2 3	
Discharge	❑	❑	1 2 3	Ever had an abnormal pap? Y/N
Odor	❑	❑	1 2 3	
Dryness	❑	❑	1 2 3	If yes, when?
Painful intercourse	❑	❑	1 2 3	
Lacerations/tears	❑	❑	1 2 3	
Yeast infections	❑	❑	1 2 3	
Bacterial vaginosis	❑	❑	1 2 3	
Irregular bleeding	❑	❑	1 2 3	
Menstrual cramps	❑	❑	1 2 3	
Mood volatility	❑	❑	1 2 3	
Irritability	❑	❑	1 2 3	
Weepiness	❑	❑	1 2 3	
Breast tenderness	❑	❑	1 2 3	
Lumps/Cysts	❑	❑		
Back aches	❑	❑	1 2 3	
Water retention	❑	❑	1 2 3	
Abdominal bloating	❑	❑	1 2 3	
Sugar cravings	❑	❑	1 2 3	

Female Health: ***continued***	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
Endometriosis	❑	❑	1 2 3	
Uterine fibroids	❑	❑	1 2 3	
Ovarian cysts	❑	❑	1 2 3	
Hot flashes/sweats	❑	❑	1 2 3	Day Night
Reproductive history: Number of pregnancies: Number of miscarriages: Number of abortions: Number of births: Date of last birth:			Date of last menstrual period: *Cycle length* regular? Y/N ❑ Short ❑ Long ❑ Irregular *Blood flow:* how many days? ❑ Light ❑ Medium ❑ Heavy ❑ Large clots	
Oral contraceptives, HRT/BHRT or other hormone treatment/ replacement used? Y/N				If so what has been used and how long?
Male Health:	**Past**	**Current**	**1 – Mild** **2 – Moderate** **3 – Severe**	**Notes:**
Prostate Prostatitis Enlargement				Difficulty with urination? Y/N Wake in the evening to urinate? Y/N If so how many times?
Scrotum Epididymitis Varicocele Pain/Lump				History of undescended testes? Y/N Do you do self- testicular exams? Y/N
Peyronie dz				How long?
Erectile dysfunction			1 2 3	How long?
Painful intercourse				
Notes:				

Past Medical History

Please list any hospitalizations and any major past illnesses or injuries (eg, broken bones, surgeries, etc):

Prescribed medications and over the counter medications – attach a separate list if necessary

Medication Name	Dose	When started?	Why?
1.			
2.			
3.			
4.			
5.			

Drug Allergies?

Any known medication allergies? Y/N

If Yes, which medications:

What allergic reaction symptoms do you experience?

Supplements – please list all vitamins/botanicals, homeopathics, etc.

Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started	Why
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Lifestyle & Social History

Diet

Do you follow any special diet type or restrictions?	Are there foods you crave strongly?
What foods make you feel poorly? Explain:	What foods make you feel the best? Explain:

How would you describe your relationship with food?

Please list typical foods consumed daily – specify typical times of day for each:

Breakfast	
Lunch	
Dinner	
Snacks	
Sweets	
Water	How much? Tap, filtered, bottled?

Please check the appropriate box below to indicate the frequency of consumption:

	Daily	Weekly	Monthly	Occasionally (1-2x per mo)	Rarely (1-2x per yr)	Never
Sugar						
Artificial sweeteners						
Fast food						
Fried food						
Processed food						
Flour/baked goods						
Caffeine						
Soda?						
Alcohol?						

Notes/details:

Habits

Do you smoke cigarettes? Y/N	Packs per day?	Duration of habit?
	Past Use?	If so, how long ago did you quit?
Do you use recreation drugs? Y/N	If Y, what type?	
	How often?	
	Past Use?	If so, how long ago did you quit?
Have you ever been treated For drug/alcohol addiction? Y/N	If Y, describe:	How long ago?

Sleep

How many hours of sleep do you get regularly each night?		Time you go to bed?
Do you fall asleep easily? Y/N	Do you sleep soundly? Y/N	Time you get up?
Do you wake rested? Y/N	What is your AM mood like?	

Notes:

Exercise

Do you exercise regularly? Y/N	How often?	For how long?

What type of exercise(s) do you do?

Spiritual practices

Do you have any spiritual practices you follow? Y/N	If yes, what kind?

Occupation

What is your occupation?	Do you like your work? Y/N
Number of hours worked per week:	Do you like your work environment? Y/N If no, please explain:

Stress Level

Rate 1-10 (1 = Very Low, 10 = High)	Source(s)of stress:

What do you do to cope with stress?

Relationship Status

_____Single _____in a relationship _____Married _____ Divorced _____Widowed	Happy with your status? Y/N

Do you Have Children**?** Y/N
If yes, number, age and gender of children:

1.

2.

3.

4.

5.

Sense of Well-being

Rate your sense of wellbeing from 1-10 (1 = Very Low, 10 = High)	Predominant emotional state?

What do you do to regularly support your health and well-being?

What challenges do you face with your efforts to maintain health?

Where do you feel you could use more support?

Palisades Natural Medicine Financial Policy

Palisades Natural Medicine is a cash-based practice that accepts cash, check or credit card payment. Payment is required on the day services are rendered. We do not file insurance claims but we will provide you with a "superbill" that contains the diagnosis and procedure codes required for insurance reimbursement. Palisades Natural Medicine assumes no responsibility for services not reimbursed by your insurance company.

I have read, understand, and agree to the above policies:

_____

Please Print Your Name

_____

Signature Date