

Basic Office Questionnaire

Heal Naples
3375 Pine Ridge Rd. Suite 204
Naples, Florida 34109
1-239-325-6499

Thank you for choosing our clinic! In order to serve you properly, we need the following information. All information is confidential.

****We require proof of identification for patient and if applicable patient guardian. For minors the permission to treat patient is required from both parents. Consent for treatment, below, must be signed by both parents. Guardians please provide official proof of guardianship.**

Office Use Only

Patient _____ Parent/Guardian _____

Identification provided

Authorization for Treatment of Minors

I authorize treatment by the providers of Healing Arts Partnership/Holistic Health West for my child or the minor under my guardianship. I am legally entitled to do so and have provided identification for said child and myself. I have also provided proof of guardianship if applicable.

Signature

Date

Signature

Date

Demographics

Date _____ Patient Name (first, last, MI) _____

Soc. Sec # _____ Male ___ Female ___ Birth date _____

Phone: (____) _____ Cell: (____) _____ Email: _____

Address: _____ City/Zip: _____ State: ___ CENTRY _____

Do you reside in the United States () yes () no () Part time CENTRY: _____

Check appropriate box: () Minor () Single () Married () Divorced () Widowed () Separated

Responsible Party (if not patient)

Minor Parent or Guardian('s) _____

Guardian Circumstance () Parent () Foster Parent () Other _____

Parent or Guardian Employer: _____ Work Ph: (____) _____

Phone: (____) _____ Cell: (____) _____ Email: _____

Address: _____ City/Zip: _____ State: ___ CENTRY _____

Primary Care Physician

If you would like us to forward your records to your primary care physician, please request this at each visit and provide us with the FAX number.

Name _____ ()M.D. ()N.D. ()Other

Phone: (____) _____ FAX: (____) _____

Address: _____ City/Zip: _____ State: ___ CNTRY _____

Release of Information

I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Health History

Drug allergies: _____

Please state your **main health concern:** _____

Describe your **diet:** _____

Height: _____ **Weight:** _____ Are you concerned about your weight _____

Smoking: ()Yes ()No ___ # per day ___ # of years ___ Years Quit _Pipe _Cigar _Chew

Alcohol Use: ()Never ()Daily ()Weekly Other _____

Exercise: ()Never ()Daily ()Weekly Other _____

Caffeine: ()Never ()Occasional ()Daily ___ # of servings ()Coffee ()Pop () _____

Chemical/Occupational Exposures: ()Asbestos ()Amalgam fillings – How Many _____

Other: _____

Food Sensitivities: _____

Environmental Sensitivities: _____

Drugs: (Please check all of the following that apply)

Allergy Medications	Blood Pressure Med	Estrogen Hormone	Nasal Sprays	Thyroid
Antacids	Blood Thinners	Heart Medication	Nitroglycerine	Tranquilizers
Anti Depressant	Cortisone	Insulin	Shots _____	Water Pill (diuretic)
Antibiotics	Decongestant	Laxative	Sleeping Pills	Weight Loss
Asthma Medicine	Diabetes Med.	Marijuana	Steroids	Vitamins
Birth Control	Digitalis	Mood Stabilizer		

Family History: Check all of the following in your immediate family (parents, siblings, children)

Alcoholism	Diabetes	High Blood Pressure	Parkinson's	Thyroid
Cancer	Heart Disease	Multiple Sclerosis	Stroke	

Dates Of Last Exams:

Physical Exam _____
Eye Exam _____
Dental Exam _____
Chest X-Ray _____
Electrocardiogram _____

Men Only:

() Discharge from Penis () Prostrate Trouble () Stream Weak or Slow
() Swelling or Pain in Testes () Date of Vasectomy

Women Only:

Age menstruation began _____ Last menstrual period date _____
Menstruation ___ Irregular
 ___ Regular
 ___ Painful
 ___ Heavy ___ Light () Yes () No; is there any recent change?
Number of pregnancies: _____ Number of births: _____
Type of birth control: _____ How long: _____
IUD () Yes () No Years inserted: _____ Date of last mammogram: _____
History of breast disease: _____