

Valley Naturopathic Family Medicine
Dr. Emily Maiella ND
432 Greenfield Road
413.230.662

DATE _____

Last Name: _____ First Name: _____

Telephone: _____ Birthdate: _____ Sex: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

SS#: _____

Employer/School: _____

Home Phone: _____ Work Phone: _____ Cell phone _____

Mother and Father Name s (minors only): _____

Emergency Contact and phone number: _____

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		
5.		

What goals do you have for your visit today? _____

Have you ever consulted a Naturopathic physician, an Acupuncturist, a Nutritionist or a Counselor before?
(please circle)

Do you have any questions about the care that you've chosen today? _____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

Please list any severe or life-threatening allergies: _____

Explain: _____

Past History:

Hospitalizations: _____

Serious Illnesses and Injuries: _____

Date of last physical/annual exam _____ Date of last blood tests: _____

Social History:

Please circle those that apply: Single Married Significant other

Do you have children? If so, what are there names and ages? _____

Personal and Family History:

Please check the “yes” box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a “P” for past or “C” for current. Indicate the relationship or the word “self” in the “Relationship” column.

	YES	RELATION	DATES RESOLVED Past(P)/Current(C)		YES	RELATION	DATES RESOLVED Past(P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

How did you hear about us? (Circle One) Newspaper Ad News Story Mailer/Flyer Website
 Workshop/Event Medical Referral Friend/Family Insurance Co. Other:

