

# VALLEY NATUROPATHIC FAMILY MEDICINE

Dr. Emily Maiella N.D.

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DATE \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone \_\_\_\_\_  
(which is best to reach you at?)

Email address: \_\_\_\_\_

Mother and Father Name s (minors only):  
\_\_\_\_\_

Emergency Contact and phone number: \_\_\_\_\_

Married Single Significant Other Do you have children? \_\_\_\_\_ Ages: \_\_\_\_\_

PRESENT HEALTH CONCERNS: PLEASE USE BACK OF SHEET IF NECESSARY

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.		

Have you ever consulted a Naturopathic physician, an Acupuncturist, a Nutritionist or a Homeopath before?

**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:** \_\_\_\_\_:

**Hospitalizations:** \_\_\_\_\_

**Where did you grow up? Where have you lived in the past?**

\_\_\_\_\_

**Serious Illnesses and Injuries:** \_\_\_\_\_

\_\_\_\_\_

**Date of last physical/annual exam** \_\_\_\_\_ **Date of last blood tests:** \_\_\_\_\_

**Who is your current Primary Care Physician? Phone and fax #** \_\_\_\_\_

**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/D rug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Lyme Disease			
Epilepsy				Other			

**How did you hear about me?** Newspaper? Which one?  
 Friend/Family Insurance Co. Other:

Mailer/Flyer

Website

Workshop/Event

Medical Referral