

Rachel M. Anderson, ND
Annapolis Natural Health, LLC
 115 Ridgely Ave, Annapolis, MD 21041
 Phone: 410-268-2025 Fax: 410-268-2035

New Client Registration Form

All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them during your visit with Dr. Anderson.

Client Information/Profile

| | | | | |
|---|--|-----------------------|--------------------------------|--|
| Name: | | Date of Birth: | Gender: M F Other | |
| Address: | | | | |
| Home Phone: | | Cell Phone: | Work Phone: | |
| May Dr. Anderson leave voice messages at any of the above numbers (please indicate which number)? | | | | |
| Relationship Status (please circle): Single Partnered Married Divorced Other | | | | |
| Number of people in household: | | Children? | | |
| Occupation: | | | Employer/School: | |
| Education Completed (please circle): High School Some College College Graduate Degree Other | | | | |
| Emergency Contact: | | phone: | relationship to client: | |
| Are you currently under medical care (please circle)? Yes No | | | | |
| If yes, what condition(s) are you under care for? | | | | |
| Who is your Primary Care Physician (PCP)? | | | | |
| Clinic Name, Address, and Phone: | | | | |
| Please list other health care professionals from whom you receive care (name, specialty, and phone if possible). | | | | |
| | | | | |
| How did you find Dr. Anderson? | | | | |
| Have you ever consulted with or been treated by a naturopathic doctor, acupuncturist, chiropractor, nutritionist or massage therapist before? (please circle all that apply) | | | | |

Health Concerns

please list in order of importance to you

| | |
|---|--------------------------------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| Are you currently pregnant? | If yes, how many weeks? |
| What goals do you have for your visit with Dr. Anderson today? | |
| | |
| | |
| What are your overall health and wellness goals? | |
| | |
| | |
| | |

| | |
|--------------|----------------|
| Client Name: | Date of Birth: |
|--------------|----------------|

Medications and Supplements

| |
|--|
| Medications and Dose (include all prescription and over-the-counter medications): |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| Supplements and Dose (include all vitamins, minerals, herbs, homeopathics): |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |

Health History

| |
|--|
| Drug Allergies or Reactions: |
| Other Allergies or Reactions (food, environmental, etc.): |
| History of Serious Illness, Hospitalization or Surgeries (description and date): |
| Childhood Illnesses (please circle all that apply): Chicken Pox Measles Mumps Rubella German measles Rheumatic Fever Strep Throat Other: |
| Have you ever been physically or emotionally abused? |
| Do you currently have concerns with abuse/violence in your life? |
| Are you safe in your home? |

Exam and Imaging History

Indicate date, doctor's name, or place of most recent tests

| | |
|---------------------|------------------|
| Physical Exam | HIV test |
| Pap Smear | Chest X-ray |
| Prostate Exam | EKG |
| Mammogram | STD Screen |
| Colonoscopy | Cholesterol test |
| TB test | Blood glucose |
| Bone density test | Urinalysis |
| Other physical exam | Other blood test |
| Other imaging test | Other test |

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Date of Birth:

Review of Systems

Please check if you currently have or have had in the past:

| General | Past | Current | Doctor's Notes |
|-----------------------------------|-------------|----------------|-----------------------|
| Weight loss or gain | | | |
| Fever or chills | | | |
| Fatigue | | | |
| Heat or Cold Intolerance | | | |
| Cold Hands and Feet | | | |
| Sweats or Night Sweats | | | |
| Excessive Thirst | | | |
| Skin | Past | Current | |
| Dryness | | | |
| Eczema | | | |
| Rashes or Itching | | | |
| Sores | | | |
| Mole changes | | | |
| Hair or nail changes | | | |
| Easy Bruising | | | |
| Head | Past | Current | |
| Headache | | | |
| Head Trauma | | | |
| Eyes | Past | Current | |
| Blurred Vision | | | |
| Glasses or Contact Lenses | | | |
| Dry Eyes | | | |
| Eye Pain | | | |
| Glaucoma | | | |
| Discharge from Eyes | | | |
| Ears | Past | Current | |
| Earaches | | | |
| ringing in Ears | | | |
| Hearing Loss | | | |
| Nose | Past | Current | |
| Sinus Congestion or Infection | | | |
| Bleeding | | | |
| Discharge | | | |
| Post Nasal Drip | | | |
| Mouth / Throat | Past | Current | |
| Sores | | | |
| Bleeding Gums | | | |
| Toothaches / Cavities | | | |
| Hoarseness of Voice | | | |
| Recurrent/persistent sore throat | | | |
| Bitter or Metallic Taste in Mouth | | | |
| Lungs | Past | Current | |
| Asthma | | | |
| Shortness of Breath | | | |
| Chest Pain or Tightness | | | |
| Persistent Cough | | | |

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| Lungs, continued | Past | Current | Doctor's Notes |
|---------------------------------|-------------|----------------|-----------------------|
| Wheezing | | | |
| Bronchitis | | | |
| Emphysema | | | |
| Pneumonia | | | |
| Tuberculosis | | | |
| Cardiovascular | Past | Current | |
| Heart Palpitations/Arrhythmia | | | |
| High Blood Pressure | | | |
| Low Blood Pressure | | | |
| Heart Murmurs | | | |
| Heart Disease | | | |
| Heart Attack | | | |
| Stroke | | | |
| Pacemaker | | | |
| Blood Clots in Legs or Lungs | | | |
| Swelling (edema) of Feet/Legs | | | |
| Circulatory Problems | | | |
| Varicose Veins | | | |
| Peripheral Arterial Disease | | | |
| Gastrointestinal | Past | Current | |
| Loss of or Excess Appetite | | | |
| Nausea or Vomiting | | | |
| Difficult or Painful Swallowing | | | |
| Eating Disorders | | | |
| Indigestion or Heartburn | | | |
| Ulcer | | | |
| Gas / Bloating | | | |
| Constipation | | | |
| Diarrhea | | | |
| Blood in Stool | | | |
| Mucus in Stool | | | |
| Undigested Food in Stool | | | |
| Black or Tarry Stool | | | |
| Colitis/ Crohn's Disease | | | |
| Hernia | | | |
| Hemorrhoids | | | |
| Anal Discomfort | | | |
| Gallbladder Disease | | | |
| Hepatitis (type) | | | |
| High Cholesterol / Lipids | | | |
| Liver Disease | | | |
| Urinary | Past | Current | |
| Pain with Urination | | | |
| Increased Urinary Frequency | | | |
| Urinary Frequency at Night | | | |
| Incontinence | | | |
| Urinary Tract Infection | | | |
| Kidney Disease | | | |

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| Musculoskeletal | Past | Current | Doctor's Notes |
|--------------------------------|-------------|----------------|-----------------------|
| Muscle Pain / Spasm / Strain | | | |
| Joint Pain / Sprain | | | |
| Osteoarthritis | | | |
| Rheumatoid Arthritis | | | |
| Osteoporosis | | | |
| Weakness | | | |
| Trauma / Swelling | | | |
| Endocrine | | | |
| Diabetes | | | |
| Thyroid Disease | | | |
| Tremor | | | |
| Hormone Therapy | | | |
| Breast Tissue | | | |
| Breast Lumps | | | |
| Breast Pain | | | |
| Nipple Discharge | | | |
| Blood / Lymphatic | | | |
| Anemia | | | |
| Bleeding Tendencies | | | |
| Blood Transfusion | | | |
| Persistent Swollen Lymph Node | | | |
| Blood / Lymph Disease | | | |
| Allergic / Immune | | | |
| HIV / AIDS | | | |
| Cancer / Chemotherapy | | | |
| Autoimmune Disease | | | |
| Hay Fever / Asthma / Eczema | | | |
| Drug Allergies | | | |
| Food Allergies | | | |
| Environmental Allergies | | | |
| Neurologic | | | |
| Epilepsy/ Seizures/Convulsions | | | |
| Fainting | | | |
| Dizziness or Vertigo | | | |
| Problems with Speech | | | |
| Problems with Walking | | | |
| Problems with Coordination | | | |
| Paralysis / weakness | | | |
| Numbness | | | |
| Multiple Sclerosis | | | |
| Psychologic | | | |
| Anxiety | | | |
| Depression | | | |
| Chemical Dependency | | | |
| Phobias | | | |
| Memory Loss | | | |
| Mood Changes | | | |
| Psychiatric Care | | | |

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Male Health Information

| Condition | Past | Current | Doctor's Notes |
|---------------------------------|------|---------|----------------|
| Testicular Pain / Swelling | | | |
| Impotence / Sexual Difficulties | | | |
| Prostate Problems | | | |
| Sexually Transmitted Infection | | | |

Female Health Information

| Menstrual History | Obstetric History | | | |
|--|---|------|---------|---|
| Age at first period: | Have you ever been pregnant? | | | |
| Date last menstrual period began: | Age at first pregnancy: | | | |
| Are your periods regular? | Number of pregnancies: | | | |
| Number of days between periods: | Number of living children: | | | |
| Number of days of menstrual flow: | Number of stillbirths: | | | |
| Heaviness of flow (number of pads or tampons in 24 hours): | Number of miscarriages: When in pregnancy? | | | |
| Color of flow: | Number of tubal pregnancies: | | | |
| Clots? (please circle) Yes No | Number of abortions: | | | |
| Pain with menstrual period? Yes No | Number of Ceasarian sections: | | | |
| Menopause? Yes No | Date of last pregnancy: | | | |
| Ovarian cyst? Yes No | Difficulty conceiving? Yes No | | | |
| Uterine fibroids? Yes No | Difficulty with pregnancy? Yes No | | | |
| Hysterectomy? Yes No If yes, date: | Difficulty with labor and delivery? Yes No | | | |
| PMS Symptoms (circle all that apply): None Bloating | Difficulty with breast feeding? Yes No | | | |
| Breast Tenderness Acne Mood Swings Fatigue | Future OB plans? Yes No | | | |
| Digestive Changes Headache Other: | | | | |
| Vaginitis Symptoms | Never | Past | Current | Risk Factors |
| Discharge | | | | History of abnormal Pap smear? Yes No |
| Irritation / Itching | | | | Did your mother take DES? Yes No |
| Vaginal Dryness | | | | Do you do self-breast exams? Yes No |
| Odor | | | | Do you have annual gynecological exams? Yes No |
| Pain with Sex | | | | Hormone replacement therapy? Yes No |
| Trichomoniasis | | | | History of sexually transmitted infections? Yes No |
| Bacterial Vaginosis (BV) | | | | |
| Yeast Infection | | | | |
| Doctor's Notes: | | | | |
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Family Medical History

| | | | | | |
|-------------------------|----------------|------------------|----------|-------------------|-------|
| Mother (please circle): | | Living | Deceased | Cause of death: | Age: |
| Father (please circle): | | Living | Deceased | Cause of death: | Age: |
| Siblings: | Number living: | Number deceased: | | Causes of deaths: | Ages: |
| Children: | Number living: | Number deceased: | | Causes of deaths: | Ages: |

| Has any family member had: | Yes | Which Relative and Age of Onset? | Doctor's Notes |
|------------------------------|-----|----------------------------------|----------------|
| Diabetes | | | |
| Severe allergies | | | |
| Stroke | | | |
| Heart Disease | | | |
| Heart Attack | | | |
| Blood Clots in Legs or Lungs | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Kidney Disease | | | |
| Osteoporosis | | | |
| Hepatitis | | | |
| Thyroid Problems | | | |
| Colitis / Crohn's Disease | | | |
| Tuberculosis | | | |
| Birth Defects | | | |
| Alcohol or Drug Addiction | | | |
| Breast Cancer | | | |
| Colon Cancer | | | |
| Ovarian Cancer | | | |
| Uterine Cancer | | | |
| Other Cancer | | | |
| Mental Illness/Depression | | | |
| Alzheimer's Disease | | | |
| Other: | | | |
| | | | |

Lifestyle and Social History

| Habits | Yes | No | Details | Doctor's Notes |
|----------------------------------|-----|----|--|----------------|
| Current Tobacco Use | | | Packs per day: | |
| Past Tobacco Use | | | Packs per day: | |
| Quit Smoking | | | When? | |
| Alcohol consumption | | | Types: Drinks per week: | |
| Recreational Drug Use | | | Type: | |
| Treated for drug/alcohol abuse? | | | When? | |
| Seat Belt Use | | | | |
| Caffeine Use (coffee, tea, cola) | | | Type: Cups per day: | |
| Regular Exercise | | | Types: How long and how frequent? | |

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