

The following pdf form should allow you to fill it out on your computer, attach to an email and send back to me at: [ncnc@drkatringoto.com](mailto:ncnc@drkatringoto.com)

You may also print it and fill it out by hand. If you are filling it out by hand, please print, and contact me using the contact page on this website for instructions on returning the form.



**NEW PATIENT HISTORY FORM**

**To our new patients:** To help us establish you with our Naturopathic practice, please provide us with your complete health history including all physical and mental symptoms.

Date: \_\_\_\_\_

**Personal History**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) Age \_\_\_\_\_

Occupation \_\_\_\_\_ Birthplace \_\_\_\_\_ (City & Country)

Height \_\_\_\_\_ (inches) Weight \_\_\_\_\_ (lbs.)

Referred by: \_\_\_\_\_

**ALLERGIES:** Example: Food, Pollens, Odors, Medicines, Pets etc...

**CHIEF COMPLAINT / REASONS FOR THIS CONSULTATION:** (if possible, rank in terms of importance to you)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Additional problems or concerns you would like to be addressed:**

\*Note: we may not be able to address every problem during the course of one treatment.

Current Medications	Dose	Times / Day / Prescribers
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Current Herbs / Vitamins/ Homeopathy/ Supplements	Dose	Times / Day / Prescribers
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\* Note: If additional space is need, add to last page.

**PAST MEDICAL, SURGICAL & TRAUMA HISTORY**

Patient Name: \_\_\_\_\_

List prior illness, injury, hospitalization, surgery, and/or trauma: \_\_\_\_\_

Date/Month and Year: \_\_\_\_\_

Reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**PERSONAL AND FAMILY HISTORY**

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

**SOCIAL HISTORY** (check those that apply)

**Patient Name:** \_\_\_\_\_

<b>Marital status:</b> <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed	<b>Education level completed:</b> <input type="checkbox"/> high school <input type="checkbox"/> college <input type="checkbox"/> professional school <input type="checkbox"/> other: _____	<b>Memories of your childhood</b> <input type="checkbox"/> Mostly happy <input type="checkbox"/> Mostly painful <input type="checkbox"/> Normal <input type="checkbox"/> don't recall	<b>Do You Find Your Life</b> <input type="checkbox"/> Generally Unsatisfactory <input type="checkbox"/> Too Demanding <input type="checkbox"/> Boring <input type="checkbox"/> Satisfactory
<b>Living arrangement:</b> <input type="checkbox"/> alone <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> significant other <input type="checkbox"/> children (list sex/ages): _____ <input type="checkbox"/> Major stresses in last 2 years <input type="checkbox"/> Money <input type="checkbox"/> Job <input type="checkbox"/> Marriage <input type="checkbox"/> Home Life <input type="checkbox"/> Children <input type="checkbox"/> other stress _____			

**Pertinent travel history:** (out of USA, epidemic areas)

**LIFESTYLE / SELF-CARE ISSUES**

Do you smoke cigarettes?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, how many? # _____ yrs. _____ packs per day
Did you ever smoke?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, when did you quit? _____
Do you drink alcohol?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, how much? Type _____ & _____ drinks per week
Do you drink caffeine beverages?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, which? _____
Do you use recreational drugs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, which? _____
Do you manage stress well?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE <input type="checkbox"/> NEED HELP
Do you exercise regularly?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If no, why? _____
Do you enjoy your job?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If no, why? _____
Do you allow time to unwind and relax?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If no, why? _____
Do you sleep soundly?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your sex life?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your social life?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your spiritual life?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If no, why? _____
Is your diet healthy enough?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE <input type="checkbox"/> NEED HELP

**Typical breakfast** \_\_\_\_\_

**Typical lunch** \_\_\_\_\_

**Typical dinner** \_\_\_\_\_

**Typical snacks** \_\_\_\_\_

**Devices**

**Do You Use:**

____ Eyeglasses	____ Contact Lens	____ Hearing Aid	____ Dentures
____ Brace (Neck, Back)	____ Pacemaker	____ IUD, Diaphragm	____ Artificial Limbs

Check any symptoms that currently apply to you:

**Constitutional**

- poor appetite
- fevers
- chills
- food craving
- weight loss
- weight gain
- fatigue

**Eyes**

- eye pain
- blurred vision
- poor vision \_\_\_ day
- poor vision \_\_\_ night
- wear corrective lenses
- near \_\_\_ far sighted
- other

**Ears, Nose**

- ringing ears
- nosebleed/polyp
- postnasal drip
- sinus problems
- trouble with taste/smell
- poor hearing
- earaches/ infections
- sneezing/ discharges

**Immune System**

- too many infections
- allergies to food
- allergies to environment
- other concerns

**Blood System**

- lymph gland swelling
- anemia
- easy bruising

**Mind Symptoms**

- memory
- temper/anger
- emotional
- sleep

**Mouth, Throat**

- tongue discoloration
- bad breath
- teeth problems
- grinding teeth
- tonsillitis/ adenoids
- facial pain
- sore throat
- ulceration tongue
- gum bleeding

**Heart & Circulation**

- chest pain
- lightheadedness
- palpitations
- cold hands/feet
- fainting
- swelling feet
- blood clots
- varicose veins

**Breathing & Lungs**

- shortness of breath
- wheezing or asthma
- repeated colds/ flu
- cough dry/ irritating

**Sexual Organs**

- sores on genitals
- lumps or swelling
- erection problems
- premature ejaculation
- pain with sex
- infertility
- repeated infections
- aversion to sex

**Thermal State**

- hot
- chilly

**Muscles, Bones & Joints**

- neck pain
- back pain
- muscle pain
- painful joints: R \_\_\_ L \_\_\_
- shoulder \_\_\_ elbow
- hip \_\_\_ knee \_\_\_ ankle
- wrist \_\_\_ fingers
- joint swelling
- muscle weakness
- muscle cramps

**Skin, Hair**

- psoriasis
- warts
- freckles
- itching, hives
- hair loss
- dry skin, eczema

**Nerves, Movement, Brain**

- seizures
- nerve pain
- poor balance
- poor coordination
- tremors or shaking
- headaches

**Women**

- pelvic pain
- vaginal discharge
- painful periods
- premenstrual syndrome
- hot flashes
- itching or soreness
- irregular menses
- leucorrhoea

**Digestion & Intestines**

- indigestion
- belching/ flatulence
- difficulty swallowing
- heartburn/ ulcer
- nausea
- liver trouble
- vomiting
- diarrhea
- cramping bowels
- food allergies
- constipation
- abdominal pain
- rectal pain/ itching
- hemorrhoids/ piles
- blood in stool

**Urine, Kidney, Bladder**

- painful urination
- wake up to urinate
- kidney stones
- loss of control
- frequent urination
- sudden urging
- blood/pus urine
- urine infection UTI

**Reproductive**

- age period started
- # of pregnancies
- # abortions
- # miscarriages
- # live births
- children currently living
- age menopause \_\_\_
- past infertility

**Additional Symptoms --**

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IF NOT NOTED IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/OR NON-PERTINENT.

**HEALTH SCREENING HISTORY****Patient Name:**

List the date of your most recent test or exam.

Mammogram \_\_\_\_\_ Pap Smear \_\_\_\_\_ Self Breast Exam \_\_\_\_\_ Breast Exam by Doctor \_\_\_\_\_

Blood test for Cholesterol \_\_\_\_\_ Blood Sugar \_\_\_\_\_ Other Blood tests \_\_\_\_\_

Immunizations: Tetanus \_\_\_\_\_ Hepatitis \_\_\_\_\_ MMR \_\_\_\_\_ Flu Shot \_\_\_\_\_

Test for Blood in stool \_\_\_\_\_ Rectal Exam \_\_\_\_\_ Feeling the Prostate \_\_\_\_\_ Scope Lower Bowel \_\_\_\_\_

Self Exam Testicle \_\_\_\_\_ Testicle Exam by Professional \_\_\_\_\_

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	EKG	EEG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other							

A complete case record will be analyzed for Naturopathic treatment. This is a confidential record and will be kept in the office. Information contained here will not be released to anyone without your authorization to do so.

**Name:**

\_\_\_\_\_

**Date:** \_\_\_\_\_**Patient/ Guardian signature:** \_\_\_\_\_**Mailing Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone Numbers: (Home)** \_\_\_\_\_ **(Cell)** \_\_\_\_\_**Email** \_\_\_\_\_**Emergency Contact (name and phone number):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Financial Policies and Disclosures**

Please read and sign that you have read, complete and agree to the following:

1. New Creation Naturopathic Center (Dr. Goto) does not bill all insurance plans. At the time of visit, please request a receipt to submit to your insurance.
2. The fee for our services is \$300 per hour. First office visit lasting approximately 1½ to 2 hours and the subsequent ones are 1½ hours. The appointments are tailored to address your needs as an individual. You receive personally designed remedies and treatments for your specific needs. All consultations are to be paid at the time of service. All major credit cards are welcome.
3. Please provide the office with 24–48 hour notice, if you are unable to keep your appointment. There is a \$150 deposit that is charged at the time of making the appointment. The deposit will be used towards the visit fee. Cancellation without 24-48 hour notice will engender a \$150 no show fee.
4. Phone consultations with prior arrangements are priced at \$300 per hour (\$75 per 15 minutes).
5. Dr. Goto holds an active Pharmacist license to practice Pharmacy in the State of Washington. Bring your prescription medicines to the appointment to have your pharmaceutical questions answered.
6. There are no narcotics on premises.
7. Consent for treatment: By signing this, I give New Creation Naturopathic Center permission to provide me with all their services at the inclusive rate stated above, with the exception of tax free dispensing items that are charged separately.
8. Release of information: By signing this, I give this office permission to release information required by law or insurance regulation to insurance agencies involved in my case. This does not give permission for any other release of information by this office, which has not been authorized by me.

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

Name (printed): \_\_\_\_\_

Date \_\_\_\_\_

Signature: \_\_\_\_\_