MATTHEW FISEL, ND
NATUROPATHIC PHYSICIAN

PATIENT PROFILE

NOTE: Naturopathic care is only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire.

Patient Name_____ Age___ Date of Birth __/__/____
Sex: F M

Street Address_____ City_____ State____
Zip_____

Daytime Phone_____ Evening Phone_____

Occupation_____ Employer_____

Email Address_____ SSN____-____-_____

Emergency
Contact_____Phone_____

Insurance
Provider_____

Referring
Physician_____

How did you hear about us?
_____

Reason for visit today:
_____

Primary Health Concerns (in order of importance):
1._____
2._____
3._____
4._____

HISTORY OF PRESENT ILLNESS/REVIEW OF SYMPTOMS
Please mark "now" or "past" next to all areas that apply to you past and present health

HEENT

___ headaches ___ earaches ___ neck lumps/swelling
___ dizziness ___ ringing in ears ___ dental problems
___ blurry vision ___ difficulty hearing ___ sore throat
___ fainting/blackouts ___ nosebleeds ___ sore/ bleeding gums
___ loss of balance ___ loss of smell ___ difficulty swallowing
___ eye pain/ red eye ___ hoarse voice ___ cold or canker sore
___ cataracts/ glaucoma ___ grinding teeth ___ impaired speech

Chest

____ wheezing ____ chest colds ____unexplained fever
____ cough up blood ____ palpitations ____ rapid/ skipped beats
____ cough up phlegm ____ chest pain ____ high blood pressure
____ shortness of breath ____ night sweats ____swollen feet or ankles

Abdomen

____ stomach pain ____ constipation ____loss of appetite
____ indigestion ____ diarrhea ____ excessive appetite
____ nausea ____vomiting ____ blood in stool
____ blood in vomit ____ gas/ bloating ____ light colored stool
____ yellow skin/ jaundice ____ clay colored stool ____ rectal pain/ itching

Genitourinary

____ recurrent bladder infections ____ frequent urination ____ blood in urine
____ urge to urinate ____ kidney stones ____ genital sores
____ sexually transmitted infection ____ sexual difficulty ____ incontinence
____ difficulty urinating ____ pain with urination ____ genital discharge

Musculoskeletal

____ aching muscles ____ broken bones ____ sore joints
____ numbness/ tingling ____ weakness ____ leg cramps
____ restless legs ____ swollen joints ____ tender points

Skin

____ acne ____rashes ____ easy bruising
____ itching ____ lesions ____ hives

Endocrine

____ always cold ____ chronic fatigue____ carbohydrate cravings
____ always hot ____ weakness ____ increased thirst

Nervous

____ anxiety ____ foggy thinking ____ loss of memory
____ loss of sensation ____ lack of strength ____ lack of concentration
____ tremor ____ convulsions ____ paralysis

Blood, Immune

____ painful lymph nodes ____ anemia ____ swollen glands
____ frequent bleeding ____ fluid retention ____wounds heal slowly

Male Reproductive

____ prostate problems ____ infertility ____ painful erection

____ swelling, pain in testicles ____ discharge ____ painful urination
____ trouble maintaining erection ____ difficulty or premature ejaculation

Female Reproductive

____ lumps in breast(s) ____ pelvic pain ____ pain with intercourse
____ breast pain ____ vaginal discharge ____ vaginal itching/ burn
____missed periods ____ heavy period ____ lack of sexual desire
____ spotting between periods ____difficulty having orgasms ____ genital eruptions

Age of first menses _____ Did you have a normal puberty? Yes No
Periods occur every ___ days. Regular? Yes No Periods usually last ____ days
First day of last period _____

____ # of pregnancies ____ # of births ____# of miscarriages ___# of abortions
Any complications of pregnancy? Yes No If yes, please explain:_____
Are you currently sexually active? Yes No Current form of contraception _____ Have you ever used birth control pills? Yes No If yes, how long? _____

Mental/ Emotional

____ depressed mood ____ restlessness ____ mental confusion
____ suicidal thoughts ____ excessive worry ____ mood swings
____ angered easily ____ loneliness ____ frequent crying
____ afraid of being alone ____ critical of others ____ suspicious/ jealous
____ shy/ timid ____ scary dreams ____ confident/ secure

Past Medical History

Drug and other known allergies: _____
_____
List any medications, vitamins, minerals, herbs or other supplement you are presently taking:
_____
_____
When did you last receive medical care, and for what reason?
_____
Do you have a history of antibiotic use?
_____
Do you have a history of a yeast or fungal infections?
_____

Hospitalizations (reasons why, after effects)	Date
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Please list any significant family history (including grandparents, aunts/uncles, parents, siblings), such as cancer, heart disease, and diabetes:

_____

_____

What is your nationality?

_____

SOCIAL/ ENVIRONMENTAL

List any current health habits (tobacco, alcohol, drugs, etc.) that may be contributing to your current health problem and for how long.

_____

Do you exercise? (Include type and frequency)

_____

What are your hobbies?

_____

You currently live with?spouse___partner___parents___friends___children___alone___
Are you? married___ divorced___ widowed___ single___ in a relationship____
How many hours do you sleep nightly? ____ Do you wake rested? Yes No
Do you have any problems with your sleep?

_____

Describe your energy level from 1-10 (on the average)_____
When during the day is your energy best?_____ worse? _____
Circle any of the following that you have been exposed to in the past. In addition, circle anything you may have a heightened sensitivity to:

pesticides mold dust mercury (or other metals) solvents radiation
herbicides toxic fumes or chemical second hand smoke dry cleaning chemicals
mold new building or car other chemicals (please list)

_____

_____

Please list any other problems or concerns that have not been previously noted.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

THANK YOU FOR YOUR COOPERATION, PATIENCE AND THOROUGHNESS

I agree to pay for services rendered according to Matthew Fisel, ND's rates and terms. Accounts are due and payable in full *at time of service by check, cash or credit card* only. I fully understand that *I will be financially responsible for any charges that my insurance provider fails to reimburse, including laboratory, supplement, and office fees*.

I hereby authorize Matthew Fisel, ND to directly receive payment of pertinent insurance benefits; to release information including protected health information to insurance companies and other related third parties as needed in relation to the filing for or collection of payment for provided services; to obtain records from other sources as needed in relation to patient diagnosis and treatment; and to convey information through various means as needed in accordance with the Notice of Privacy Practices, a copy of which was made available to me.

I acknowledge that I must give 24 hours notice to cancel an appointment. If I do not call within 24 hours of my appointment, a $50.00 charge (not billable to my insurance) will be billed to my account. I understand that this fee must be paid before I reschedule any appointment.

I hereby acknowledge that I am personally responsible for all co-payment, deductibles, non-covered services and required referrals according to my insurance policy. I agree to pay all applicable charges accrued and to promptly pay any balance in full. I understand that my account will be charged $25.00 for any checks returned due to non-sufficient funds. I also agree that I am responsible for any collection and/or attorney fees. I agree that I am responsible to promptly alert Matthew Fisel, ND should there be any changes related to insurance and other information I provided above.

Name and Signature of Responsible Party:

_____ Date:_____

I authorize Matthew Fisel, ND, to call the following:

Home_____ leave message on Home line_____

Office_____ leave message on Office line_____

Cell_____ leave message on Cell line_____

Signed:_____

I consent to the services to be rendered by Matthew Fisel, ND and/or other licensed naturopathic physicians who treat me serving as backup for Matthew Fisel, ND. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels is in my best interest at the time. I intend this consent to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

I, OR MY REPRESENTATIVE, HAVE READ AND FULLY AGREE TO THE ABOVE STATEMENTS.

Patient signature _____ Date_____