THE NEW LIFE CENTER
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ADULT HEALTH HISTORY FORM

Date of 1st Appointment._____

Name_____Gender: M____F____Birth Date_____Age_____

Name you wish to be called_____Marital Status:_____Height_____Weight_____

Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Mobile Phone_____

Email Address_____ Social Security Number _____

Education_____Occupation_____Position_____

Who is the nearest relative or friend who you would like to have called in case of an emergency?

Name _____ Relationship: _____ Phone: _____

How Did You Learn About The New Life Center / Dr. Alvarado?_____

Please list what you want to achieve by coming to The New Life Center:

_____

_____

_____

What problems, difficulties, illnesses, or complaints would you like remedied?

_____

_____

_____

Have you ever been to a ☐ Naturopathic Physician ☐ Acupuncturist ☐ Other "Natural Practitioner"

Do you have a pacemaker, artificial heart valve, or any artificial device in your body? ☐ Yes ☐ No

If yes, please describe: _____

What is your level of mental stress? ☐ low ☐ moderate ☐ high

What is the pace of your work? ☐ slow ☐ medium ☐ fast

Please check any below that have been a problem for a parent, grand-parent, sister or brother:

☐ cancer ☐ diabetes ☐ stroke ☐ heart problems ☐ high blood pressure

☐ arthritis ☐ celiacs ☐ mental disorder ☐ alcoholism/addiction ☐ thyroid/adrenal

☐ asthma ☐ epilepsy ☐ kidney disease ☐ autoimmune or inherited _____

Please check any of the following you are exposed to:

☐ dust ☐ mold ☐ dampness ☐ fumes

☐ chemicals ☐ paint ☐ solvents ☐ insecticides

☐ varnishes ☐ lacquers ☐ excessive heat ☐ excessive cold

What is your current energy level? (1=low; 5=high) 1 2 3 4 5

Do you have any contagious disease? Yes No If yes, please describe:

_____

Are you receiving any care for physical well-being now? If so from whom?_____

For what purpose?_____

Are you receiving any care for emotional well-being now? If so from whom?_____

For what purpose?_____

Were you happy as a child? Yes No What fostered or prevented your happiness?

_____

_____

_____

Are you happy now? Yes No What fosters or prevents your happiness now?

_____

_____

_____

Please rate the quality of the following different parts of your life (1=low; 5=high):

Family	1	2	3	4	5
Friends	1	2	3	4	5
Romance/relationship(s)	1	2	3	4	5
Spirituality	1	2	3	4	5
Health	1	2	3	4	5
Recreation/fun	1	2	3	4	5
Career	1	2	3	4	5
Financial	1	2	3	4	5
Physical Environment					
___Where you live	1	2	3	4	5
___Where you work	1	2	3	4	5
___Other	1	2	3	4	5

Please list, using 1 or 2 words each, the five or ten things you personally value most in life. They may be ideals, emotions, objects, attitudes, situations, behaviors, skills, abilities or anything else, whatever you value most._____

_____

_____

_____

In the boxes on the far left of this list, please check the **Past** or **Now** columns for past and current issues.

Past	Now	Please leave this space blank.				
		Please leave this space blank.				
		Please leave this space blank.				
		Please leave this space blank.				
		Please leave this space blank.				
		Please leave this space blank.				
		Please leave this space blank.				
		Please leave this space blank.				
		Please leave this space blank.				
		Head injury				
		Headaches				
		Migraine headaches				
		Earaches				
		Excess ear wax				
		Impaired hearing				
		Ringing in ears				
		Blurry or double vision				
		Eye pain/strain				
		Cataract				
		Glaucoma				
		Eye tearing				
		Eye dryness				
		Spots in vision				
		Eye injury				
		Excess saliva				
		Dry mouth				
		Gum problems				
		Teeth-grinding				
		Root canal(s)				
		Jaw/TMJ problems				
		Difficulty swallowing				
		Mouth sores				
		Asthma				
		Bronchitis				
		Cough				
		Breathing difficulty				
		Breathing pain				
		Short of breath				
		Wheezing				
		Spitting up blood				
		Emphysema				
		Pleurisy				
		Tuberculosis				

Past	Now	Please leave this space blank.				
		Pneumonia				
		Allergy / Hay fever				
		Sinus infection / problems				
		Frequent colds/flu/sore throat				
		Neck lump(s)				
		Chest pain				
		Angina				
		Heart disease				
		Heart murmur				
		Heart palpitations				
		Irregular heart beat				
		Fast heart beat				
		Slow heart beat				
		High blood pressure				
		Low blood pressure				
		Stroke				
		Blood clots				
		Ankle swelling				
		Cold hands or feet				
		Deep leg pain				
		Easy bruising				
		Varicose veins				
		Arthritis				
		Joint pain				
		Broken bone(s)				
		Shoulder pain				
		Arm pain				
		Elbow pain				
		Wrist pain				
		Hand pain				
		Hip pain				
		Leg pain				
		Knee pain				
		Ankle pain				
		Foot pain				
		Neck pain				
		Upper back pain				
		Lower back pain				
		Sciatica				
		muscle twitching				
		Muscle spasms or cramps				
		Fibromyalgia				
		Osteoporosis				

Past	Now	Please leave this space blank.				
		Stomach problems				
		Digestive problems				
		Intestinal problems				
		Bowel problems				
		Irritable bowel syndrome				
		Colitis				
		Crohn's disease				
		Diarrhea				
		Constipation				
		Hemorrhoids				
		Blood in stool				
		Black stool				
		Ulcer				
		Abdominal pain/cramps				
		Appendicitis				
		Bloating/gas				
		Heartburn				
		Change in appetite				
		Nausea/vomiting				
		Fatigue after meals				
		Pancreatitis				
		Jaundice				
		Hepatitis				
		Other Liver disease				
		Gall bladder disease				
		Painful urination				
		Frequent urination - day				
		Frequent urination - night				
		Difficulty starting urination				
		Difficulty continuing urination				
		Weak urinary stream				
		Urinary "dribbling"				
		Incontinence				
		Urinary tract infections - UTI's				
		Kidney stones				
		Other Kidney disease				
		Thyroid problem				
		Goiter - swollen thyroid				
		Adrenal problem				
		Pituitary problem				
		Fatigue / tiredness				
		Hypoglycemia				
		Diabetes				
		Excessive thirst				

Past	Now	Please leave this space blank.				
		Sensitive to cold				
		Sensitive to heat				
		Hair loss				
		Night sweats				
		Hot flashes				
		Hormonal problems				
		Other endocrine problems				
		Male Issues				
		Testicular problems				
		Prostate problems				
		Inguinal hernia				
		Impotence				
		Premature ejaculation				
		Discharges or sores				
		Decreased Libido				
		Sexual difficulty or pain				
		Sexually transmitted infection				
		Painful Intercourse				
		Female Issues				
		Irregular menstrual cycles				
		Painful menses				
		Heavy menstrual flow				
		Medium menstrual flow				
		Light menstrual flow				
		Blood clots in menses				
		Bleeding between menses				
		Cervical dysplasia				
		Abnormal PAP				
		Ovarian cyst(s)				
		Sexual difficulty or pain				
		Sexually transmitted infection				
		Pelvic inflammatory disease				
		Premenstrual syndrome (PMS)				
		Breasts tender				
		Breast lump(s)				
		Nipple discharge				
		Vaginal itching				
		Vaginal discharges or sores				
		Difficulty conceiving				
		Endometriosis				
		Painful intercourse				
		Decreased Libido				
		Hot flashes				
		Other menopausal symptoms				

Please answer the next 11 lines with a Yes, No, Number or Date						
		Are you pregnant now?				
		Age at 1st menses:				
		Last menses date:				
		Length of cycle (monthly):				
		Days of flow (menses):				
		Number of pregnancies:				
		Number of live births:				
		Number of miscarriages:				
		Number of abortions:				
		Last PAP/exam date:				
		Do you do breast self-exams?				
Please return to checking the **Past** or **Now** columns again						
Past	**Now**	Please leave this space blank.				
		Fainting				
		Dizziness or vertigo				
		Loss of memory				
		Paralysis				
		Epilepsy or Seizures				
		Numbness or tingling				
		Muscle weakness				
		Parkinson's				
		Multiple sclerosis				
		Neurological disorder				
		Acne or boils				
		Skin color changes				
		Dry Skin				
		Oily Skin				
		Eczema				
		Hives				
		Rash				
		Itching				
		Other skin condition				
		Chronic infections				
		Ongoing infections				
		Allergy - food				
		Allergy - environmental				
		Mold sensitivity				
		Candida/yeast infections				
		Swollen or enlarged glands				
		Lumps or tumors				
		Cancer				
		Vaccine reactions				
		Slow wound healing				

Past	**Now**	Please leave this space blank.				
		Chronic pain				
		Mental / emotional problems				
		Extreme stress				
		Anxiety or Nervousness				
		Depression				
		Suicide plan(s)				
		Suicide attempt(s)				
		Mood swings				
		Irritability				
		Frequent crying				
		Lack of confidence				
		Low self-esteem				
		Fear				
		panic				
		Grief				
		Guilt				
		Shame				
		Loneliness				
		Mental confusion				
		Compulsiveness				
		Eating disorder				
		Concentration difficulties				
		Insomnia				
		Heavy metal poisoning				
		Food poisoning				
		Chemical poisoning				
		Toxic exposure				
		Cold sweats				
		Major injury				
		Extreme pain				
		Chronic fatigue				
		Weight change				
		Abnormal bleeding				
		Abnormal discharges				
		Swelling / edema				
		Unusual lumps				
		If you have any other health				
		issues please list them here:				

Please **CHECK** all the questions below which are true for you and **CIRCLE** any that are most relevant.

- ☐ Were you raised by both parents?
  If not, who raised you?_____
- ☐ Did you receive kindness, love, and attention from them?
- ☐ Did you do things together just for fun?
- ☐ Did you get along well with:
  - ☐ your parent(s) or guardian?
  - ☐ our sibling(s)?
  - ☐ your schoolteachers?
  - ☐ your classmates?
- ☐ As a child did anyone in your family have a problem with alcohol, drugs, or addictions?
- ☐ Was anyone mentally / physically abusive?
- ☐ Was there a particular family member who was especially kind and loving?
- ☐ Were you happy as a child?
- ☐ Are you happy now?
- ☐ Have you been married more than once?
- ☐ Do you get along well with your partner?
- ☐ Do you enjoy being with your partner?
- ☐ Do you do things together just for fun?
- ☐ If you have children, what are their ages?
  _____
- ☐ Do you get along well with all of them?
- ☐ Do you enjoy being with all of them?
- ☐ Do you do things together just for fun?
- ☐ How many people live in your house?____
- ☐ Have you or has anyone in your home
  - ☐ been mentally or physically abusive?
  - ☐ been addicted to drugs or alcohol?
  - ☐ been especially kind & loving to you?
- ☐ Are you kind and loving to your family and friends?
- ☐ Do you do something daily for your own enjoyment?
- ☐ Do you spend significant time outside?
- ☐ Do you have hobbies or similar interests?
  please list _____
- ☐ Do you enjoy your work?
- ☐ Do you have more than one job?
- ☐ How many hours do you work weekly?_____
- ☐ Do you get along well with
  - ☐ your employer?
  - ☐ your fellow employees?
  - ☐ people you supervise?
  - ☐ your friends?
- ☐ Do you consider your health to be good?

Do you:

- ☐ exercise regularly?
- ☐ awaken rested?
- ☐ have regular bowel movements?
- ☐ have a satisfactory sex life?
- ☐ have a vacation each year?
- ☐ watch TV? - how much? _____
- ☐ drink alcohol - how much?_____
- ☐ use recreational drugs? how often_____
- ☐ drink coffee - how much? _____
- ☐ use birth control?
  - ☐ pills
  - ☐ other
- ☐ use tobacco?
  how much_____ how long_____

☐ Are you aware of having allergies?
Please list: _____

☐ Do you follow any special way of eating?
Please describe: _____

☐ Have you ever been hospitalized or had surgery? Please explain: _____

☐ Do you have a significant religious or spiritual focus? If yes please describe:

☐ Do you do any form of stress management? If yes please describe:

If you need more space for any question(s) below please use the back of this page.

Do you have any ideas about why you have your problem(s)? _____

Do you have any ideas about what may be needed for you to heal?_____

Please list all prescribed medication, over-the-counter medication, vitamin and food supplements, herbs, homeopathics, and any other remedies and treatments which you are using now. Thank You.

What you use	What it's for	How much used	How long used

Thank you for taking the time to complete this form. It will help me to help you. I look forward to meeting with you.

Gil Alvarado, ND, LAc

Appointments and Payment

We have found it is best to be sure that everyone is clear about appointment and payment policies before their first appointment. The policies are simple. This note is to insure your understanding. If you have any questions or concerns please call The New Life Center and we will answer them for you.

Your first appointment at The New Life Center is foundational and comprehensive. It is usually about 3 hours long. The fee is $325. Future visits will be about 1½ hour long and the fee is $105. Nutritional supplements and herbal remedies, etc. are charged separately. If for any reason you are unable to keep an appointment please give us as much notice as possible. If you can't keep your appointment, call at least 24 working day hours before your appointment, or you will be responsible for full payment. (call on Friday by 10:00 AM if you can't keep a Monday 10:00 AM appointment, etc. – weekends and national holidays are not working days) We regret that past experience has made this policy necessary.

Full payment is due at the time services are rendered. Should this ever not be possible, please make specific financial arrangements with us *prior* to your visit. We do not routinely send bills for services. If your insurance company covers our services the invoice/receipt you receive from us will have the information your insurance company needs to reimburse you. We cannot accept payment directly from insurance companies. If you have any questions please call us and we will be happy to answer them .

Thank you again for coming to The New Life Center. We appreciate and value the privilege of serving you and will do our best to help you receive the assistance you need and deserve.

Please sign and date this form and mail or fax it to us along with your Health History Form. Thank you.

I have read and agree to the information and policies described above.
Name (please print) _____

Signature_____ Date_____