INTEGRATIVE NATURAL HEALTH

Patient Information

Please allow adequate time to complete the inventory as thoroughly as possible. All information is voluntary, confidential and for the sole purpose of evaluation and/or treatment assessment by certified and credentialed practitioners within the Integrative Natural Health.

Please complete the form and return to:

Email: Dr.Frenzel@CTinHealth.com

Telephone: (203) 951-3359

www.CTinHealth.com

Patient Demographic Information

First Name:	Middle Name:	Last Name:	
Home Phone:	Work Phone:	Mobile Phone:	
Street Address:	City:	State:	Zip:
Birth date:	Age:	Social Security #:	What is your preferred method of communication? ❑ Telephone ❑ Email ❑ Fax
Occupation:		Email:	
If Retired, Previous Occupation:		Employer/School:	
Marital/ Partnership Status: ❑ Married ❑ Single ❑ Divorced ❑ Significant Other Name:		Number & Age of Children:	
Emergency Contact:	Relationship:	Phone:	
Primary Physician:	Phone:	Office Address:	

How did you hear about us? (check all that apply) ❑ Referred by Physician, Name: ❑ Referred by CIM patient/ friend, Name:

❑ Online search engine ❑ AANP Naturopathic website/ Find an ND ❑ Newspaper/ Magazine ❑ Word of Mouth ❑ Other:

The Connecticut Integrative Natural Health collects payment at the time of service. What will be your usual source of payment?

❑Cash ❑ Check ❑ VISA/ Mastercard

We require a credit card number OR a deposit when you schedule your appointment.

I. Summary of Current Condition
Please describe the current condition or illnesses for which you are seeking treatment at the center. Please include the date when the illness began.
This condition interferes with ❑ Work ❑ Sleep ❑ Exercise. This condition is getting ❑ Worse ❑ Better ❑ Staying the same.
What do you believe is the cause?
How is this condition being treated?

II. Other Conditions
Please list other health concerns:

III. Goals and Expectations
Please tell us your goals and expectations for our clinic:

IV. Surgical / Injury / Hospitalization History (please attach list if you need more space)

Have you had blood transfusion? Yes No

Please list prior surgeries, injuries and hospitalizations, including dates:

V. Review of Symptoms / Conditions

Head	Neck	General	Mental / Emotional
❑ Headaches	❑ Goiter	❑ Chronic fatigue or tiredness	❑ Anxiety, nervousness
❑ Migraines	❑ Neck lumps	❑ Frequent colds	❑ Poor memory
❑ law TMI problems	❑ Neck pain or stiffness	❑ Infections, chronic	❑ Depression
❑ Hair Loss	❑ Whiplash injury	❑ Slow would healing	❑ Concentration / focus, difficult
❑ Ear pain	Chest	❑ Heat or Cold intolerance	❑ Mood swings
❑ Ear infections	❑ Chest pain / pressure	❑ Increasing hunger	❑ Tension, stress
❑ Ears, itchy	❑ Palpitations / heart fluttering	❑ Increasing thirst	Urinary
❑ Hearing problems	❑ Difficult breathing	❑ Excessive sweating	❑ Frequent infections
❑ Ringing / tinnitus	❑ Pain with breathing	❑ Night sweating	❑ Inability to hold urine
❑ Wax, excessive	❑ Chronic cough	❑ Fainting / Light headedness	❑ Inability to completely empty bladder
❑ Blurry Vision	❑ Shortness of breath	❑ Dizziness / Vertigo	❑ Increased urinary frequency
❑ Color blindness	❑ at night	❑ Numbness or Tingling	❑ Urinary frequency at night
❑ Diminished night vision	❑ lying down	❑ Tremor	❑ Urgency with urination
❑ Double vision	❑ with exercise / exertion	❑ Back pain	❑ Low force of urine
❑ Dry, red, gritty eyes	❑ Spitting up blood	❑ Muscle pain	❑ Pain with urination
❑ Eyes, itchy	❑ Wheezing	❑ Muscle spasms! cramps	❑ Bed wetting
❑ Eye pain	Extremities	❑ Muscle weakness, tiredness	Female
❑ Glasses / Contacts	❑ Joint pain or stiffness	Digestion / Elimination	❑ Bleeding between cycles
❑ Spots in Eyes! floaters	❑ Joint heat and redness	❑ Abdominal / stomach pain	❑ PMS
❑ Tearing, excessive	❑ Joint swelling	❑ Alt. diarrhea/ constipation	❑ Endometriosis
❑ Hay fever	❑ Swelling in ankles	❑ Belching/ burping	❑ Difficulty getting pregnant
❑ Nose bleeds, frequent	❑ Leg pain	❑ Blood in stool	❑ Hot flashes
❑ Red nose and/or face	❑ Cold hands and feet	❑ Change in stool	❑ Breast pain
❑ Runny nose	Skin	❑ Difficult bowel movement	Male
❑ Sinus problems	❑ Acne	❑ Change in appetite/ thirst	❑ Penile discharge
❑ Stuffiness, congestion	❑ Rashes	❑ Constipation	❑ Penile sores
❑ Bad breath	❑ Rushing / hot flashes	❑ Diarrhea	❑ Pain with sexual intercourse
❑ Dental cavities/ fillings #	❑ Eczema	❑ Fatigue after eating	❑ Difficulty getting / maintaining erection
❑ Root canals #	❑ Hives	❑ Ratulence / gassiness	❑ Sexual difficulties
❑ Dentures	❑ Boils	❑ Heartburn! Acid reflux	❑ Testicular lump
❑ Frequent sore throat	❑ Itching	❑ Hemorrhoids	❑ Testicular pain
❑ Frequently clear throat	❑ Color change	❑ Nausea	
❑ Gum problems / Periodontal Disease	❑ Lumps	❑ Pain in rectum / anus	
❑ Hoarseness	❑ Psoriasis	❑ Itching in rectum / anus	
❑ Mouth sores	❑ Moles	❑ Painful stool	
❑ Cold sores / oral herpes	❑ Sun sensitivity	❑ Swallowing difficulty	
❑ Mouth, dryness	❑ Tight skin	❑ Vomiting	
❑ Sore tongue, lips	❑ Easy bleeding! bruising		
❑ Teeth grinding	❑ Varicose veins		
❑ Swollen glands	❑ Rosacea		
❑ Tonsils / Adenoids removal			

VI. Medical History: Family & Self

Key: Se=Self Fa=Father Mo=Mother Sis=Sister Bro=Brother

Your Birthplace: Race & Ethnicity background: Mother: Father:

Alcoholism	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Infertility	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Allergies	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Kidney Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Anemia / Blood Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Kidney Stone	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Arthritis, Rheumatoid	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Liver Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Arthritis, Osteo	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Lung Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Asthma	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Lyme Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Autoimmune Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Mental Illness	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Cancer Type	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Mouth, Throat Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
		Muscular Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Chicken Pox	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Neurological Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Depression or Anxiety	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Osteopenia	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Diabetes	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Osteoporosis	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Drug Addiction	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Pain, chronic	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Eating Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Skeletal Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Epilepsy / Seizures	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Skin Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Gallbladder Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Stroke	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Gastrointestinal Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Syphilis	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Glaucoma/Cataracts	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Thyroid Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Gout	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Tuberculosis	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Hay Fever / Hives	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Urinary Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
Heart Disease	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro	Vascular Disorder	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro
High Blood Pressure	❑ Se ❑ Fa ❑ Mo ❑ Sis ❑ Bro		

Father's health: ❑ Excellent ❑ Good ❑ Average ❑ Poor Age if living Age, when deceased —

Mother's health: ❑ Excellent ❑ Good ❑ Average ❑ Poor Age if livin Age, when deceased

VII. Medications taken during the last 5 years							
Your Pharmacy name & telephone #:							
Category:	Medication:	Dosage	Now (√)	Past (√)	Medication:	Dosage:	Now (J) Past (J)
Antibiotics:							
Pain:							
Blood Pressure:							
Cholesterol:							
Depression/ Anxiety/ Sleep:							
Hormones:							
Thyroid:							
Diabetes:							
Digestion:							
Allergies/ Asthma:							
Weight Control:							
Skin Creams:							
Other:							

VIII. Current Over the Counter, Nutritional Supplements & Herbs. (e.g.: Aspirin, Decongestant, Ginkgo). Please attach a fist if you need more space.					
Brand/ Store:	Supplement:	Dosage:	Brand/ Store:	Supplement:	Dosage:

IX. General Review

Weight, current:

Weight, 1 year ago:

Maximum weight:

My ideal body weight:

I consider my weight to be

❑ Not a factor in my present illness

❑ Somewhat a factor

❑ A significant factor

Height:

Do you sleep well? ❑ Yes ❑ No

Do you awaken feeling rested? ❑ Yes ❑ No

Do get enough sleep? ❑ Yes ❑ No

Average hours of sleep/ night:

My blood type is ❑ A ❑ B ❑ 0 ❑ AB ❑ + ❑ -

Do you eat 3 meals/ day? ❑ Yes ❑ No

Do you enjoy your work ❑ Yes ❑ No

Do you spend time outside? ❑ Yes ❑ No

Do you take vacations? ❑ Yes ❑ No

Average number of sick days/ year:

Do you watch television? ❑ Yes ❑ No

Hours per day:

How many hours/ day do you use a computer?

Do you follow a spiritual practice? ❑ Yes ❑ No

Type of practice/religion:

How important is spirituality in your daily life?

not important 0 1 2 3 4 5 6 7 8 very important

How important is religion in your daily life?

not important 0 1 2 3 4 5 6 7 8 very important

Energy/ Fatigue level

❑ I have abundant energy

❑ I have adequate energy to do what I need/ want to do

❑ I could use a little more energy

❑ I feel tired often

❑ I feel tired all the time

Do you exercise? ❑ Yes ❑ No

Please describe. (activity & hours/ week)

On a scale from 1 to 10, where 0 is a thoroughly easy going person and 10 is a very high-strung person, please rate how you generally consider

yourself How do you think others would rate you?

Do you drink alcohol? ❑Yes ❑ No Number of drinks/ week:

Ever treated for alcoholism? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Have you ever used tobacco? ❑ Yes ❑ No

What type?

How much per day?

For how many years?

Ever tried to quit? ❑ Yes ❑ No

Do you use recreational drugs? ❑ Yes ❑ No

Ever been treated for drug dependence? ❑ Yes ❑ No

Have you been exposed to toxic /potentially toxic chemicals? ❑ Yes ❑ No

Please list:

Ever been diagnosed with a psychiatric disorder? ❑ Yes ❑ No

Did you undergo treatment? ❑ Yes ❑ No

Do you consider yourself to be generally happy these days? ❑ Yes ❑ No

Do you have a strong support system? (people to talk to, share things with, friends and family? ❑ Yes ❑ No

Do you have a significant other? ❑ Yes ❑ No

Please identify the 3 biggest stressors in your Ife:

1)

2)

3)

If there were 3 things about yourself that you could change, what would they be?

1)

2)

3)

Please describe 2 - 3 of your greatest strengths and/or achievements

Please list main interests and hobbies/ what you do for fun:

What do you do creatively / What are your creative outlets?

X. Environment	
Is your job associated with any harmful chemicals (such as: pesticides, industrial chemicals, radioactivity) or hazardous, life threatening activity (firefighter)?	Please explain:
In and around your residence, do you use:	Pesticides? Yes____ No___ Herbicides? Yes___ No___ Cleaners: tilex, mildew removers? Yes___ No___ Natural cleaning products? Yes___ No___ Organic lawn care? Yes___ No___ Air fresheners / plug-ins? Yes___ No___ Scented candles? Yes___ No___
Do you:	Color or highlight your hair? Yes___ No___ Wear acrylic nails? Yes___ No___ Use perfumes? Yes___ No___ Use artificially scented products? Yes___ No___ Use cosmetic products? Yes___ No___ Use antiperspirant / deodorant? Yes___ No___ Use non-stick cookware? Yes___ No___ Use plastic containers / utensils? Yes___ No___