NATUROPATHIC INJECTION INTAKE
CONFIDENTIAL PATIENT CASE HISTORY

GRAHAM
Rehabilitation & Wellness

This confidential history will be part of your permanent records.

Dr. Bahareh Moshtagh, ND

PLEASE NOTE THAT FILLING OUT THIS PAPERWORK CAREFULLY, MEANS THAT TIME WILL BE SPENT MORE EFFICIENTLY WITH PHYSICIAN

Today's Date: / / Patient's Signature:_____

SSN:_____ Parent/ Spouse/ Guardian Signature: _____

Title: (*Circle)* Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name_____Nick Name: _____

Last Name: _____Middle Name: _____

Address: _____

City: _____State: _____ Zip code: _____

Mobile Phone: _____Home Phone: _____

E-mail: _____ Best contact method? _____

Can we leave personal information on your voicemail or in e-mail? □ No □ Yes

DOB: MM /DD /YYYY Age:_____ Gender: □ Male □ Female □ Unspecified

Current occupation? Employer?: _____

Race: _____Ethnicity:_____

Verification Question: *(Choose only one question by checking the question, then give the answer to that question)*

□ Name of your favorite pet? □ Make of first car? □ Favorite color?
□ Favorite movie? □ Birth city? □ Street you grew up on?

Verification answer to chosen question: _____

Who referred you to us/ How did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Is this condition: □ Improving □ Unchanged □ Getting worse

Is this condition interfering with: □ Work □ Sleep □ Daily Routine □ Other:_____

ALLERGIES: *(Environmental/ Food/ Previous Injections)* □ None
(please specify anaphylaxis and other symptoms)

To what:	Onset:	Symptoms experienced:

- Do you have an up to date **Epi- Pen** and know how to use it? □ No □ Yes
- Have you ever been diagnosed with **Asthma**? □ No □ Yes
    - Do you have an **albuterol** inhaler? □ No □ Yes

MEDICATIONS & SUPPLEMENTS: *(Please name brand if known)* □ None

Name:	Dose:	Reason:

HEALTH HISTORY

1. **Drug use:** Type:_____ Frequency:_____ *(note this is confidential)*
   _____
2. **Have you been presently diagnosed with Hypertension? □ No □ Yes**
3. **Have you been presently diagnosed with Diabetes? □ No □ Yes**
4. If YES □ **Type I** □ **Type II Recent HbgA1c value?_____%**
5. **Have you been diagnosed with cancer? □ No □ Yes Type: _____**
6. **Do you have any implants or other foreign objects in your body? □ No □ Yes, Explain:**
   _____
7. **Sleep:**
   - Do you suffer from insomnia? □ **No** □ **Yes**
   - Difficulty falling asleep? □ **No** □ **Yes**
   - Wake up feeling rested? □ **No** □ **Yes**
   - How many hours on average of sleep do you get per night?_____ is it consistent/ inconsistent? (*circle*)

PAST MEDICAL HISTORY

Primary Care Provider(s): **Name(s):** **Name(s):**	 **Number:** **Number:**
- Last Complete Physical exam: **- Last lab work:** **- Last Colonoscopy** **- Males- Last prostate exam** **- Females- Last PAP, was HPV co-testing done?** **Yes / No** **Last Mammogram**	**Date:** **Date:** **Date:** **Date:** **Date:** **Date:** **Date:**
Blood Transfusions: **Date: _____ Date: _____** **Date: _____ Date: _____** **Diagnosed with Hepatitis?** **Type:**	**Last TB skin Test:** Normal? Y/ N **Last Chest X-Ray:** Normal? Y/ N

REVIEW OF SYSTEMS

(Check only the ones you have or have had in the past)

CONSTITUTIONAL	**□ NOW**	**□ PAST**
Unexplainable weight loss	☐	☐
Unexplainable weight gain	☐	☐
Fatigue / sleepiness	☐	☐
Fever	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Fainting	☐	☐
Dizziness	☐	☐

PSYCHIATRIC	**□ NOW**	**□ PAST**
Depression	☐	☐
Loss of interest/ pleasure	☐	☐
Anxiety	☐	☐
Difficulty concentrating	☐	☐
Difficulty remembering things	☐	☐
Suicidal thoughts	☐	☐
Mood changes	☐	☐
Irritability	☐	☐

Diagnosed with a psychiatric disorder? *(List)*

_____

IMMUNE

History of autoimmune diseases?

☐MS ☐RA ☐Hashimoto's ☐Graves ☐Lupus

Sick often? □ **No** □ **Yes**

GASTROINTESTINAL

☐ Liver disease

□ Kidney disease

NERVOUS SYSTEM	**□ NOW**	**□ PAST**
Tingling/ numbness in fingers, toes, arms, legs	☐	☐
Headaches /migraines *(circle)*	☐	☐

LYMPHATIC/ BLOOD	**□ NOW**	**□ PAST**
Easy bruising	☐	☐
Easy bleeding	☐	☐
History of anemia	☐	☐

Diagnosed with a blood clotting disorder?

Yes;_____

Thank you, please submit your form to the front desk!