PATIENT NAME_____ **Date**_____

Center for Health and Healing
New Patient Medical Forms

To our new patient,

Welcome and thank you for choosing Center for Health and Healing. As a new patient to our office, it is extremely important for us to understand your current health concerns as well as your full medical history. It is likely that we are requesting more medical information than you've had to complete for other medical practices, however this additional information allows Dr. Rind to provide a more complete medical plan for you.

The following forms need to be completed by all new patients and returned to our office at least 3 business days prior to the appointment. These forms contain:

1. Present Medical Concerns
2. Review of Systems
3. Personal & Family Medical History
4. Supplements & Medications
5. Current diet details
6. Narrative History (see separate document emailed to you)

Details provide valuable clues. Please provide as much detail as you reasonably can in completing these forms.

Please write clearly and legibly

Important: If this medical information is not being completed by the patient themselves, please let us know who is completing this for them:

_____ _____
Name (Printed) Relationship to patient

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1. Present Medical Concerns

In your own words, please let us know what your primary reasons are for seeking care at CHH. Please list in the order of greatest concern.

A. _____

B. _____

C. _____

D. _____

2. Review of Systems

Instructions:

1. **Please mark an X in the second column if you currently have this symptom and**
2. **In the third column let us know how long you've had this symptom**

System	Symptom	CURRENTLY have this symptom	Have had for this long (Circle one)
EXAMPLE	COLD FEET	**X**	<1 mo 2-6 mo 6-12 mo >1yrs
General	Fatigue		<1 mo 2-6 mo 6-12 mo >1yrs
	Low grade fevers		<1 mo 2-6 mo 6-12 mo >1yrs
	Anorexia		<1 mo 2-6 mo 6-12 mo >1yrs
	Heat intolerance		<1 mo 2-6 mo 6-12 mo >1yrs
	Cold Intolerance		<1 mo 2-6 mo 6-12 mo >1yrs
	Brain fog		<1 mo 2-6 mo 6-12 mo >1yrs
Skin/Hair/ Nails	New rashes *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Bruising *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Cracked lips		<1 mo 2-6 mo 6-12 mo >1yrs
	Bug bite (tick or other) *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Dryness		<1 mo 2-6 mo 6-12 mo >1yrs
	Excessive perspiration		<1 mo 2-6 mo 6-12 mo >1yrs
	Hair loss		<1 mo 2-6 mo 6-12 mo >1yrs
	Hives		<1 mo 2-6 mo 6-12 mo >1yrs
	Itchiness *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Lack of perspiration		<1 mo 2-6 mo 6-12 mo >1yrs
	Pallor		<1 mo 2-6 mo 6-12 mo >1yrs
	Nails brittle		<1 mo 2-6 mo 6-12 mo >1yrs

System	Symptom	CURRENTLY have this symptom	Have had for this long (Circle one)
Skin/Hair/ Nails (con't)	Nails peeling		<1 mo 2-6 mo 6-12 mo >1yrs
	Thin nails		<1 mo 2-6 mo 6-12 mo >1yrs
	Thickened nails		<1 mo 2-6 mo 6-12 mo >1yrs
	Nail Fungal Infections		<1 mo 2-6 mo 6-12 mo >1yrs
	Nail ridges		<1 mo 2-6 mo 6-12 mo >1yrs
HEENT	Light sensitivity		<1 mo 2-6 mo 6-12 mo >1yrs
	Eye redness		<1 mo 2-6 mo 6-12 mo >1yrs
	Poor night vision		<1 mo 2-6 mo 6-12 mo >1yrs
	Difficulty driving at night		<1 mo 2-6 mo 6-12 mo >1yrs
	Visual problem		<1 mo 2-6 mo 6-12 mo >1yrs
	Eye dryness		<1 mo 2-6 mo 6-12 mo >1yrs
	Headaches		<1 mo 2-6 mo 6-12 mo >1yrs
	Migraines		<1 mo 2-6 mo 6-12 mo >1yrs
	Sinusitis		<1 mo 2-6 mo 6-12 mo >1yrs
	Hearing loss		<1 mo 2-6 mo 6-12 mo >1yrs
	Itching Ears		<1 mo 2-6 mo 6-12 mo >1yrs
Respiratory	Shortness of breath		<1 mo 2-6 mo 6-12 mo >1yrs
	Occasional air hunger		<1 mo 2-6 mo 6-12 mo >1yrs
	Cough		<1 mo 2-6 mo 6-12 mo >1yrs
	Difficulty breathing		<1 mo 2-6 mo 6-12 mo >1yrs
	Asthma		<1 mo 2-6 mo 6-12 mo >1yrs
	Bronchitis		<1 mo 2-6 mo 6-12 mo >1yrs

System	Symptom	CURRENTLY have this symptom	Have had for this long (Circle one)
Gastro-intestinal	Constipation		<1 mo 2-6 mo 6-12 mo >1yrs
	Diarrhea		<1 mo 2-6 mo 6-12 mo >1yrs
	Irritable Bowel		<1 mo 2-6 mo 6-12 mo >1yrs
	Abdominal pain (generalized)		<1 mo 2-6 mo 6-12 mo >1yrs
	Abdominal pain (sharp)		<1 mo 2-6 mo 6-12 mo >1yrs
	Poor Digestion		<1 mo 2-6 mo 6-12 mo >1yrs
	Excessive gas		<1 mo 2-6 mo 6-12 mo >1yrs
	Acid reflux		<1 mo 2-6 mo 6-12 mo >1yrs
Cardiovascular	Chest pain		<1 mo 2-6 mo 6-12 mo >1yrs
	Leg or ankle swelling		<1 mo 2-6 mo 6-12 mo >1yrs
	Elevated blood pressure		<1 mo 2-6 mo 6-12 mo >1yrs
	Palpitations		<1 mo 2-6 mo 6-12 mo >1yrs
	Cold extremities		<1 mo 2-6 mo 6-12 mo >1yrs
	Clotting problem		<1 mo 2-6 mo 6-12 mo >1yrs
	Bleeding Problem		<1 mo 2-6 mo 6-12 mo >1yrs
Musculo-skeletal	Muscle pain *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Muscle weakness *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Disc problems		<1 mo 2-6 mo 6-12 mo >1yrs
	Back pain		<1 mo 2-6 mo 6-12 mo >1yrs
	Short leg		<1 mo 2-6 mo 6-12 mo >1yrs
	Calf pain		<1 mo 2-6 mo 6-12 mo >1yrs
	Leg cramps		<1 mo 2-6 mo 6-12 mo >1yrs

System	Symptom	CURRENTLY have this symptom	Have had for this long (Circle one)
Musculo-skeletal (con't)	Decreased range of motion		<1 mo 2-6 mo 6-12 mo >1yrs
	Muscle weakness		<1 mo 2-6 mo 6-12 mo >1yrs
	Joint pain *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Joint swelling *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Joint stiffness		<1 mo 2-6 mo 6-12 mo >1yrs
Neck	Neck mass		<1 mo 2-6 mo 6-12 mo >1yrs
	Neck pain		<1 mo 2-6 mo 6-12 mo >1yrs
	Neck stiffness		<1 mo 2-6 mo 6-12 mo >1yrs
Neurological	Neuropathy/burning/pain *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Vertigo		<1 mo 2-6 mo 6-12 mo >1yrs
	Loss of Equilibrium		<1 mo 2-6 mo 6-12 mo >1yrs
	Numbness *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Pins & needles *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Tingling *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Unexplained weakness		<1 mo 2-6 mo 6-12 mo >1yrs
	Trouble walking		<1 mo 2-6 mo 6-12 mo >1yrs
	Clumsiness		<1 mo 2-6 mo 6-12 mo >1yrs
	Balance problems		<1 mo 2-6 mo 6-12 mo >1yrs
	Speech Problems		<1 mo 2-6 mo 6-12 mo >1yrs
	Memory Problems		<1 mo 2-6 mo 6-12 mo >1yrs
	Headaches		<1 mo 2-6 mo 6-12 mo >1yrs
	Tremor *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs

System	Symptom	CURRENTLY have this symptom	Have had for this long (Circle one)
Neurological (con't)	Incontinence stool		<1 mo 2-6 mo 6-12 mo >1yrs
	Incontinence urine		<1 mo 2-6 mo 6-12 mo >1yrs
	Seizures		<1 mo 2-6 mo 6-12 mo >1yrs
Psychiatric	Depression		<1 mo 2-6 mo 6-12 mo >1yrs
	Anxiety		<1 mo 2-6 mo 6-12 mo >1yrs
	Irritability		<1 mo 2-6 mo 6-12 mo >1yrs
	Insomnia		<1 mo 2-6 mo 6-12 mo >1yrs
	Hypersomnia		<1 mo 2-6 mo 6-12 mo >1yrs
	Inability to concentrate		<1 mo 2-6 mo 6-12 mo >1yrs
	Mood changes		<1 mo 2-6 mo 6-12 mo >1yrs
	Suicidal thoughts		<1 mo 2-6 mo 6-12 mo >1yrs
Endocrine	Excessive thirst		<1 mo 2-6 mo 6-12 mo >1yrs
	Sexual dysfunction		<1 mo 2-6 mo 6-12 mo >1yrs
	Libido change		<1 mo 2-6 mo 6-12 mo >1yrs
	Low blood pressure		<1 mo 2-6 mo 6-12 mo >1yrs
	Low body temperature		<1 mo 2-6 mo 6-12 mo >1yrs
	Cold extremities		<1 mo 2-6 mo 6-12 mo >1yrs
	Low blood sugar		<1 mo 2-6 mo 6-12 mo >1yrs
	Light sensitivity		<1 mo 2-6 mo 6-12 mo >1yrs
	Poor stress tolerance		<1 mo 2-6 mo 6-12 mo >1yrs
	Weight gain		<1 mo 2-6 mo 6-12 mo >1yrs
	Weight loss		<1 mo 2-6 mo 6-12 mo >1yrs

System	Symptom	CURRENTLY have this symptom	Have had for this long (Circle one)
Endocrine (con't)	Fatigue easily		<1 mo 2-6 mo 6-12 mo >1yrs
Thyroid	Hyperthyroid		<1 mo 2-6 mo 6-12 mo >1yrs
	Hypothyroid		<1 mo 2-6 mo 6-12 mo >1yrs
	Cysts/Nodule		<1 mo 2-6 mo 6-12 mo >1yrs
	Lower neck swelling		<1 mo 2-6 mo 6-12 mo >1yrs
Genitourinary	Frequent urination		<1 mo 2-6 mo 6-12 mo >1yrs
	Kidney disease		<1 mo 2-6 mo 6-12 mo >1yrs
	Bladder infections		<1 mo 2-6 mo 6-12 mo >1yrs
	Incontinence		<1 mo 2-6 mo 6-12 mo >1yrs
Male	Impotence		<1 mo 2-6 mo 6-12 mo >1yrs
	Prostate problems		<1 mo 2-6 mo 6-12 mo >1yrs
Female	Hot flashes		<1 mo 2-6 mo 6-12 mo >1yrs
	Trouble with cycles		<1 mo 2-6 mo 6-12 mo >1yrs
	PMS		<1 mo 2-6 mo 6-12 mo >1yrs
	Non-cycle bleeding		<1 mo 2-6 mo 6-12 mo >1yrs
	Fibroids		<1 mo 2-6 mo 6-12 mo >1yrs
	Ovarian Cysts		<1 mo 2-6 mo 6-12 mo >1yrs
	Yeast Infections		<1 mo 2-6 mo 6-12 mo >1yrs
	Other Infections *(If yes, please note detail)*		<1 mo 2-6 mo 6-12 mo >1yrs
Breast (Females, Males can fill in if relates)	Fibrocystic		<1 mo 2-6 mo 6-12 mo >1yrs
	Lump or mass		<1 mo 2-6 mo 6-12 mo >1yrs
	Tenderness *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs

System	Symptom	CURRENTLY have this symptom	Have had for this long (Circle one)
Breast (con't)	Nipple discharge		<1 mo 2-6 mo 6-12 mo >1yrs
	Nipple changes (shifting, retracting)		<1 mo 2-6 mo 6-12 mo >1yrs
	Insect bite(s)		<1 mo 2-6 mo 6-12 mo >1yrs
Hematology	Swollen glands *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Excessive bleeding		<1 mo 2-6 mo 6-12 mo >1yrs
	Enlarged lymph nodes *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
	Anemia		<1 mo 2-6 mo 6-12 mo >1yrs
	Bruising *(If yes, please note location)*		<1 mo 2-6 mo 6-12 mo >1yrs
Others not listed above			<1 mo 2-6 mo 6-12 mo >1yrs
			<1 mo 2-6 mo 6-12 mo >1yrs
			<1 mo 2-6 mo 6-12 mo >1yrs
			<1 mo 2-6 mo 6-12 mo >1yrs

2. Personal & Family Medical History

A. Specific Medical History Items:

For Dr. Rind's practice, it is important to know if you have any history of the following. Please mark an **X** beside any of the following included in your past/current medical history and if applicable, write the year of diagnosis (or occurrence) and treatment received (if any). An example is shown below.

		Part of my History	Year of Occurrence or Diagnosis	Treatment Received (if none, mark "none')
EXAMPLE	*Bacterial Infection*	**X**	*2008*	*Antibiotics x1 month. No probiotics taken with it*
Immune System history	Mold exposure			
	Yeast infections (oral, intestinal, skin, groin, vaginal)			
	Exposure to Lyme endemic area			
	Tick bite and/or bulls eye rash			
	Other major insect bites			
	Mercury Amalgams			
	Other heavy metal exposure			
	Multiple allergies			
	Chemical sensitivity			
Cardiovascular History	Heart Attack			
	Chest pains			
	Rhythm problem			
	Pacemaker			
	Valve problem			
Neurological History	Stroke			
	Traumatic brain injury			
	History of whiplash			

		Part of my History	**Year of Occurrence or Diagnosis**	**Treatment Received (if none, mark "none')**
Neurological History (con't)	Concussion			
Female Breast	Abnormal radiological study (i.e. mammogram)			
	Chest or rib trauma			
	Neck or shoulder trauma			
	Trauma or injury to breast(s)			
	Breast lump(s)			

B. Diagnosis History – Please let us know if you are currently dealing with any of the following issues, by circling the issue itself. For those that apply, answer the questions regarding that issue
(Note: any cancer diagnosis information is in the following section, do not include that here)

Medical Concern	**Ongoing or Past Issue (circle one)**		**Dates dealt with**	**Formal Diagnosis Received?**	
e.g. Sun poisoning	Ongoing	Past	June 2008	Yes	No
Chronic Fatigue	Ongoing	Past		Yes	No
Multiple Chemical Sensitivity	Ongoing	Past		Yes	No
Graves Disease	Ongoing	Past		Yes	No
Hashimotos Thyroiditis	Ongoing	Past		Yes	No
Arthritis	Ongoing	Past		Yes	No
PMS	Ongoing	Past		Yes	No
Fertility disorder	Ongoing	Past		Yes	No
Migraines	Ongoing	Past		Yes	No
Myalgia	Ongoing	Past		Yes	No
Lyme Disease	Ongoing	Past		Yes	No

For those issues circled above, please write the medical issue/diagnosis and then detail what treatment has been tried or is currently being given. Write "none" if applicable

Medical Concern	Current Treatments	Past treatments
e.g. Arthritis	• Anti inflammatory diet	• Medication (Aspirin) daily

C. Cancer History – Please mark an "**X**" after any cancer diagnosis you've received. Include method of diagnosis, year of diagnosis, and treatment received. An example is shown below.

Type of Cancer	Part of History ("X" for yes)	Stage	Method of Diagnosis	Year of Diagnosis	Treatment Received (if any)
e.g. Breast	**X**	*1A*	*MRI + biopsy*	*2010*	*Lumpectomy + radiation x6 months*
Brain					
Bone					
Breast					
Colon					
Leukemia					
Prostate					
Thyroid					
Skin					

Type of Cancer	Part of History ("X" for yes)	Stage	Method of Diagnosis	Year of Diagnosis	Treatment Received (if any)
Other	List any not listed above				

D. Surgical History – Please list surgeries you have had. Include the reason for surgery, what year they occurred, and if there were any complications during or following surgery. Two examples shown below

Type of Surgery	Reason for Surgery	Month/Year of Surgery	Complications during or post surgery
E.g. Breast implant	*Cosmetic reasons*	*March 1995*	*None*
E.g. Hysterectomy	*painful menses*	*Jan 2001*	*Scar tissue formation*

E. History of Injuries – Please complete accordingly

Type of Injury	Details	Date of Injury	Age at time of injury	Symptom onset post surgery (if applies)
e.g. Broke collar bone	*Gymnastics fall*	*November 1995*	*10*	*Chronic neck pain*

F. Female History – Please complete accordingly

a. Mark one: **Are you** _____ Post Menopausal……..Age @ onset: _____ (if applicable)
_____ Peri Menopausal……..Age @ onset: _____ (if applicable)
OR
_____ having period cycles

b. **Age menses began:** _____

Were menses painful, heavy, abnormal in anyway when they began?

What about now? Are they painful, heavy, abnormal in any way currently?

c. History of Hormonal support:

Are you current taking any female hormone support? (birth control included) _____ Yes _____ No

If yes, what kind (s) _____ **Is it bioidentical?** _____ Yes _____ No

_____ **Is it bioidentical?** _____ Yes _____ No

_____ **Is it bioidentical?** _____ Yes _____ No

d. **What is the date of your last mammogram?** _____

Findings: _____

e. **Have you had any breast studies (MRI, Ultrasound, biopsy)? If so, what were they?**

G. Allergies – Please list any allergies other than Food Allergies which will be detailed in another section

	Type	**Degree of Allergy**	**Reaction**
EXAMPLE	*Penicillin*	*Mild*	*Rash*
Environmental			
Medications			
Chemical			
Herbal/Supplements			

H. Family History- Please mark an **X** beside any of the following included in your family medical history and if applicable, write the family member with such history. We are most concerned about immediate family members: mother, father, children, brothers/sisters, grandparents

Condition	In Family History?	Type (if applies)	Family member
e.g. Cancer	**X**	*Colon*	*Father*
Obesity			
Cancer			
Thyroid Disorder			
Auto Immune disease			
Lyme Disease			
Multiple chemical sensitivity			
Diabetes			

3. Current Supplements & Medications

Please fill out the relevant information to anything you currently take on a regular basis

Medications

Name of Medication	Dose	Frequency	Managing Prescriber
e.g. Armour Thryoid	*30mg*	*Twice daily*	Dr. Smith (Primary Care)

**If you take more than this table allows, please send us an attached list of your supplements with the above needed information included

Supplements

Name of Supplement	Dose	Frequency	Notes
e.g. Vitamin D3	*2,000IU*	*1x daily*	

**If you take more than this table allows, please send us an attached list of your supplements with the above needed information included

5. Current Diet

A. Please mark with an "X", or circle, where on the following food groupings that reflects your current diet

Vegan	**Vegetarian**	**Mixed**	**Heavy animal sourced**
No animal sources of food, all plant based	Dairy, eggs, and/or fish are only animal sources Mostly plant based	½ diet animal sources, ½ plant based	More than ½ of diet is from animal sources, little plants

Diet mostly processed/ prepared foods (prepared includes restaurants)	**Diet 50/50 with processed & whole foods prepared at home**	**Diet mostly whole foods prepared at home**

I **don't buy any organic**	I buy **some** organic and/or non-GMO	I buy **mostly** organic and/or non-GMO	I buy **ALL** organic and/or non-GMO/grass fed/ free range

B. **Describe your typical breakfast, lunch, dinner, snack, and beverages during the day**

Breakfast	Lunch	Dinner	Snack	Beverages
e.g. -Cereal w/milk	-Restaurant sandwich + chips	-Salad w/chicken or fish	-crackers w/hummus	-coffee, water -diet soda in PM

C. Childhood diet: How would you describe your childhood diet?

D. Have you ever experimented with certain dietary regimes and if so, what were your responses?

E. **Current Food allergies/sensitivities AND/OR foods you're currently avoiding for other reasons**

Food Eliminated	For How Long	Reason for Elimination (allergy, sensitivity, preference)
e.g. Dairy (cow)	2 months	Suspected sensitivity b/c feeling better without it

Please let us know how you learned about Dr. Rind: _____

_____