



Welcome. To insure optimal care please fill out the following form and bring it with you to our first meeting. Please provide us with all possible information regarding your health so that we may establish a successful and long-term working relationship.

I look forward to meeting you.

Warm Regards,

Dr. Raina Lasse and Dr. Susan Saccomanno

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work): \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Education: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Married: \_\_\_\_ Separated: \_\_\_\_ Divorced: \_\_\_\_ Widowed: \_\_\_\_ Single: \_\_\_\_ Partnership: \_\_\_\_

Live with: Spouse: \_\_\_\_ Partner: \_\_\_\_ Parents: \_\_\_\_ Children: \_\_\_\_ Friends: \_\_\_\_ Alone: \_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Have you ever seen a Naturopathic physician before? \_\_\_\_\_

Describe your experience: \_\_\_\_\_

How did you hear about my practice? \_\_\_\_\_

Has any other family member been seen at my practice? \_\_\_\_\_

Next of Kin or other to reach in case of emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_

ID#: \_\_\_\_\_ Group # \_\_\_\_\_

Deductible \_\_\_\_\_ Copay \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Deductible \_\_\_\_\_ Copay \_\_\_\_\_

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will assist me greatly in my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me in guiding you with your health needs.

[1] Why did you choose to come to see me as a Naturopath?

What do you know about our approach?

[2] What three expectations do you have from this visit today?

What long-term expectations do you have from working with me as a Naturopathic Doctor?

What expectations do you have of me personally as your physician or health care provider?

[3] What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed.)

0%    1        2        3        4        5        6        7        8        9        10    100%

[4] What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (please list)

[5] What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and which may interfere in adhering to the therapeutic protocols which I will be sharing with you?

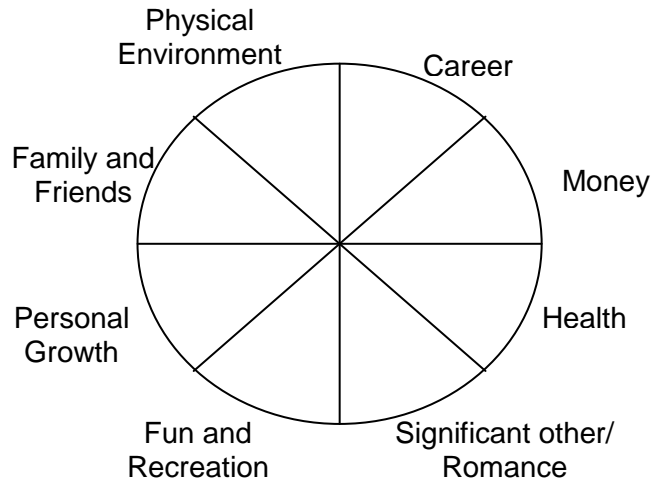
[6] Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, please shade in your level of satisfaction in each area as it relates to you.

For example: if you are extremely happy in your career, shade in the entire pie shape for career.

Do this for each area starting from the center point radiating outwards.



Are you currently receiving health care?   Y     N

If yes, for what and from whom? \_\_\_\_\_

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What are your most important health concerns? List as many as you can in order of importance.

- [1] \_\_\_\_\_
- [2] \_\_\_\_\_
- [3] \_\_\_\_\_
- [4] \_\_\_\_\_
- [5] \_\_\_\_\_
- [6] \_\_\_\_\_
- [7] \_\_\_\_\_

Do you have any known contagious diseases at this time? Y N

If yes, what? \_\_\_\_\_

Typical Food Intake

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

For The Following, Please Circle

Y = You have the condition NOW N = Never had P = Significant problem in the past

Habits

Main interests and hobbies? \_\_\_\_\_

Do you exercise? Y N If yes, how often? \_\_\_\_\_

What type? \_\_\_\_\_

|                                 |       |                           |       |
|---------------------------------|-------|---------------------------|-------|
| Average 6-8 hrs. sleep?         | Y N P | Enjoy your work?          | Y N P |
| Sleep well?                     | Y N P | Take vacations?           | Y N P |
| Awake rested?                   | Y N P | Spend time outside?       | Y N P |
| Have a supportive relationship? | Y N P | Watch television?         | Y N P |
| Have a history of abuse?        | Y N P | How many hours? _____     |       |
| Any major traumas?              | Y N P | Read?                     | Y N P |
| Use recreational drugs?         | Y N P | How many hours? _____     |       |
| Treated for drug dependence?    | Y N P | Eat three meals a day?    | Y N P |
| Use alcoholic beverages?        | Y N P | Treated for alcoholism?   | Y N P |
| How often?                      |       | Go on diets often?        | Y N P |
| _____                           |       |                           |       |
| Use tobacco?                    | Y N P | Do you eat out often?     | Y N P |
| How often?                      |       | Do you drink coffee?      | Y N P |
| _____                           |       |                           |       |
| Smoked previously?              | Y N P | Drink black or green tea? | Y N P |
| How many years? _____           |       | Drink cola/ soda?         | Y N P |
| How many packs per day? -       |       | Eat refined sugar?        | Y N P |
| _____                           |       |                           |       |
|                                 |       | Do you add salt?          | Y N P |

Do you have a religious or spiritual practice? Y N If yes, what? \_\_\_\_\_

## Family History

Do you have a family history of any of the following conditions? (please circle)

|                |           |               |                     |
|----------------|-----------|---------------|---------------------|
| Cancer         | Diabetes  | Heart Disease | High Blood Pressure |
| Kidney Disease | Epilepsy  | Arthritis     | Glaucoma            |
| Tuberculosis   | Stroke    | Anemia        | Mental Illness      |
| Asthma         | Hay Fever | Hives         | Eczema              |

Any other relevant family history? \_\_\_\_\_

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## Childhood Illness

Please circle whether you have had any of the following as a child:

|               |            |                 |
|---------------|------------|-----------------|
| Scarlet Fever | Diphtheria | Rheumatic Fever |
| Mumps         | Measles    | German Measles  |

## Hospitalizations, Surgery, Imaging

What hospitalizations, surgeries, X-rays, CAT scans, EEG and/ or EKG's have you had?

\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_

## Allergies

Are you hypersensitive or allergic to ...

Any drugs? \_\_\_\_\_  
Any foods? \_\_\_\_\_  
Environmental or chemical agents? \_\_\_\_\_

## Current Medications

Do you take or use (currently or in the past)?

|               |     |                       |     |                |     |
|---------------|-----|-----------------------|-----|----------------|-----|
| Laxatives     | Y N | Pain Relievers        | Y N | Antacids       | Y N |
| Cortisone     | Y N | Appetite Suppressants | Y N | Antibiotics    | Y N |
| Tranquilizers | Y N | Thyroid medication    | Y N | Sleeping Pills | Y N |

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking...

|           |           |
|-----------|-----------|
| [1] _____ | [2] _____ |
| [3] _____ | [4] _____ |
| [5] _____ | [6] _____ |
| [7] _____ | [8] _____ |

**Personal**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs Weight 1 year ago: \_\_\_\_\_ lbs  
Maximum weight: \_\_\_\_\_ When: \_\_\_\_\_

At what time is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_