Natural Health Improvement Center of Columbia, Md.
Dr. Lisa Gordon
5053 Durham Rd. W. Columbia, Md 410-717-6610

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____
Address _____ Apt.# _____
City _____ State _____ ZIP _____

Home Phone (____) ____-_____ Work Phone (____) ____-_____

Cell Phone(___)_____-_____

E-mail address: _____
REFERRED BY: _____
Occupation _____ Employer _____
Date of Birth _____ Age ____ Gender_____
Height _____ Weight _____

Are you pregnant? (Circle one) Yes No Not sure
If so, when is your due date? _____
Please list any complications if any.
_____

Overall health (circle one): Excellent / Good / Fair / Poor
Chief complaint (reason you are here):

_____
_____

How does the condition affect your life? In other words, what would you like to be able to do that you have trouble doing because of the condition?

_____
_____

Previous treatments for this complaint. What results did you have with each? _____
_____
_____

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Other complaints or problems: (use separate sheet if needed) _____

_____

_____

Do you follow particular dietary guidelines? Yes/No

If so, what guidelines do you follow and why?

_____

_____

Do you smoke, drink coffee, use alcohol or any other mind or body altering substances? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

Other: please specify type and amount _____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgeries you have had (with approx. dates): _____

_____

Medications you take: _____

Past Accidents or injuries: _____

If you have ever had cancer, any neurological, autoimmune or other chronic illness, or anything else that has not been included in this history form, please describe the condition, treatments you have had and dates

_____

_____

_____

_____

Confidential: Please notify me if you are HIV positive, have tuberculosis, hepatitis or any other communicable disease.

_____

_____

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Please print clearly:

Name _____ Date _____

Circle any of these conditions that you have ever experienced:

1) Dizziness 2) Neck Pain 3) Back Pain 4)Neuritis

5) Headaches or Migraines 6) Arthritis 7) Asthma

8)Allergies or Sensitivities 9) Digestive Difficulties

10) Anxiety 11) ADD 12) ADHD 13) Learning Difficulties

14) Trouble with Balance 15) Heart Illness 16) Diabetes

17) Sinus Problems 18) Insomnia 19) Foggy Thinking

Please provide details of any of the above that you circled using extra paper if necessary.

_____

_____

Who should we call in case of emergency? Include phone number:

_____

If applicable, please list tested or suspected allergies and related symptoms.

Foods_____

Seasonal_____

Medication/Other_____

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Family:

Marital Status: S M D W P _____

Name of Spouse/Partner _____

Describe health of spouse/partner:_____

Number of children if any _____

Name of Child Age Gender Health Conditions/Concerns_

_____

_____

_____

_____

Any family history of serious illnesses (circle those which apply): Cancer/ Diabetes/ Heart / Immune / Neurological / Other _____

_____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

_____

Please write what you have eaten for 2 days:

Breakfast

Lunch

Dinner

Breakfast

Lunch

Dinner

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Office Policies: Please adhere to the following guidelines.

It is my priority to give each of my patients the utmost attention and I make every effort to see each patient at his or her scheduled appointment time. I appreciate your consideration and will do my very best to honor your time as well. Accordingly, the following policies are in place:

1. As a courtesy to our other patients, some of whom have strong sensitivities, please do not smoke or wear perfume or fragrances prior to coming in to the clinic. Even fragrance that has been applied in the morning is troublesome for those whose sensitivities are strong, so please do not use it on the days you have appointments.

2. Do not eat or chew gum during the session or in the office.

Financial Policies:

3. Natural Health Improvement Center of Columbia, Md has a 48-hour cancellation policy. Late cancellations or no-shows will incur the charge of the session missed, payable at the following session or within 30 days.

4. Please arrive on time to your appointment. Late arrivals may be rescheduled and will be considered a no-show if the office schedule does not allow enough time for the appointment. Please call if you are running late to find out if you can be accommodated.

5. Payment is due at the time services are rendered and may be made in the form of cash, check, Visa, MC or Discover

I have read and agree to all the above guidelines and policies. This document is true and accurate to the best of my knowledge on this date.

Patient's Signature:_____Date _____

I agree to have Dr. Lisa Gordon treat my child _____

Parent or Legal Guardian's Signature_____

Date_____