Dr. Priscilla Monroe, RN, ND

Naturopathic Doctor
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Patient Name_____ Sex _____Date of Birth_____

If patient is a minor, name of parent or guardian_____

Address _____City _____ State_____ Zip_____

Phone _____ Message Phone _____

Patients Occupation_____ _____ ____ Full Time Part Time Retired

Patients Employer_____ Work Phone_____

Patients Employer Address_____

Marital Status_____ Name of Spouse or Partner_____

Whom may we thank for this referral?_____

Welcome to Dr. Priscilla Monroe, Naturopathic Physician. I look forward to providing all of your health care needs, with an emphasis on preventative care and health maintenance. Treatments for most disease conditions are available from infancy to advanced age. Holistic approaches and natural medicine highlight my efforts to restore normal balance and well being in your life. I welcome your questions and encourage your participation in your health care treatment.

Payment in full is expected at the time of service. I accept checks, cash, Visa, and Mastercard. Reduced billing charges help me keep **your** costs down. If it is necessary, please notify the office in *advance* if an extended payment schedule is needed and work out a payment plan with me prior to receiving services. My past due accounts are periodically turned over to a collection agency. If your account is assigned, you agree to pay all costs necessary to collect the amount due. This policy keeps me from penalizing my patients who pay their bills promptly.

Since your appointment time has been set especially for you, I ask that you please be prompt. Failure to cancel within 48 hours will result in a patient charge of $75.00.

I agree to be responsible for payment as a result of all bills incurred in this office. I have read the above policy and agree to abide by it for all services received from this office.

_____ _____

Signature (parent sign if patient is a minor) **Date**

Please list reasons you came in today:

1)_____

2)_____

3)_____

4)_____

Health Habits

Hobbies _____

Exercise: What_____ How Often_____

Sleep: Hours_____ Light_____ Sound_____ Insomnia_____

Stress Level: High_____ Average_____ Low_____ Major Stress_____

Alcohol Use: Yes_____ No_____ If yes, how much? _____

Tobacco Use: Yes_____ No_____ If yes, how much? _____

Caffeine Use: Yes_____ No_____ If yes, how much? _____

Diet (circle one): Junk food – Standard American (meat, potatoes, dessert) – Wholesome – Vegetarian – Raw Foods – Other_____

Briefly describe your diet:_____

_____

Please list all vitamins, minerals, and other food supplements you take: _____

_____

Please list all medications, both prescription and over-the-counter that you take: _____

_____

Past medical history: (Please include dates) _____

_____

_____

Major illnesses: _____

Past surgeries: _____

Please mark **"N"** for any problems you have had now and **"P"** for any past problems or conditions.

___Allergies	___Eczema	___Stroke	___Arthritis
___Headaches, frequent	___Thyroid	___Asthma	___Heart Problems
___Trauma, Major	___Blood disease	___Herpes	___Tuberculosis
___Cancer	___Hypertension	___Urinary infections	___Colds, frequent
___Hypoglycemia	___Venereal disease	___Diabetes	___Nervous breakdown
___Digestive Problems	___Neurosis/Psychosis	___Ear infections	___Pneumonia
___Other			

Past medical care: Where did you last receive medical care? _____

_____

For what reason? _____

_____

When was your last physical exam taken? _____

_____

Last dental exam? _____