GenWell Health Naturopathic Care
Genevieve Stalla, N.D.

New Visit Paperwork

Name: _____Date: _____

Address:_____

City: _____ State: _____Zip Code: _____

Telephone # (home): _____(work): _____(cell): _____

May I leave confidential voice-mail messages for you at any of the above numbers? No / Yes

(specify): **Home / Work / Cell**

E-mail address: _____

May I leave confidential E-mail messages for you at the above address? No / Yes

_____ (initials) I understand that it is possible if my personal health information is sent over email that it may be viewed by others. I recognize and accept this possibility and authorize my doctor to communicate my personal health information with me by email.

Date of Birth: _____ Gender: female / male

Emergency contact: _____

Relationship: _____

Phone: _____

Education/Degree: _____

Relationship status: Single / Married / Partnership / Separated / Divorced / Widowed

Live with: Alone / Spouse / Partner / Parents / Children / Friends/Roommate

Employment status: Full-time / Part-time / School / Retired / Not working / Other

Occupation: _____

Employer:_____

Are you seeing other healthcare providers? (Please include their names)

_____

_____

How did you hear about me?_____

_____

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Main Concerns (for any of the following questions, please include additional info on a separate page if needed)

1. _____
2. _____
3. _____
4. _____

How long have you suffered with these problems?

_____

Any other issues:

_____

_____

What have you tried doing to resolve your problem(s) that **DID NOT** work?

_____

_____

_____

How do these problem(s) interfere with the following areas in your life:

Work:_____

Family:_____

Hobbies:_____

Do you know how these problem(s) may have started?

_____

_____

Where do you picture yourself being in the next 3-5 years if these problem(s) are NOT taken care of? (Please be specific)

_____

_____

_____

What would be different or better without these problem(s)? (circle all that apply)

Less stress
Better sleep
Better self-esteem & confidence
A happier outlook on life
More & better time with family
More energy
Greater ability to work

On a scale from 1-10 (1 - very low, 10 – very high)

1. **How important is it for you to resolve your health concerns?**
2. **Do you feel that you are coachable and would enjoy having a mentor to help you?**
3. **Are you prepared to make appropriate diet & lifestyle changes that may be necessary to achieve your goals?**

How have you taken care of your health in the past? (circle all that apply)

Medications
Routine check-ups
Regular exercise
Self-education
Vitamins/supplements/herbs
Holistic practitioners
Diet & Nutrition changes
Other: _____

How did those methods work for you?

_____

Diet & Lifestyle

How healthy do you feel your current lifestyle is? (5 = very healthy; 1 = very unhealthy)

Diet 5 — 4 — 3 — 2 — 1

Exercise 5 — 4 — 3 — 2 — 1

Sleep 5 — 4 — 3 — 2 — 1

Stress 5 — 4 — 3 — 2 — 1

Typical Food Intake

Dietary preferences/restrictions:

_____

What is your favorite food? _____

Sample Day's menu (Please fill out a true sample day, and not what you think we would like you to put. We do not judge your food choices, our goal is to help adjust your food intake to best help you)

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

To Drink: _____

Medications & Supplements (please attach a separate sheet if needed)

Medications:

_____

_____

_____

Supplements:

_____

_____

_____

Allergies

Do you have allergies or reactions to...

Any drugs?

_____

Any foods?

_____

Environmental allergies (grass, pollen, dog/cat, etc)? _____

Chemicals?_____

To the best of your knowledge have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation or other toxins beyond those encountered in regular, daily life?

Family History (Provide diseases or health issues)

Mother: _____

Father: _____

Siblings: _____

Spouse: _____

Children: _____

*MGM: _____

*MGF: _____

*PGM: _____

*PGF: _____

M = Maternal (Mother) P = Paternal (Father) GM = Grandmother GF = Grandfather

Any other important family history?

_____

What is your ethnic background?

_____

PAIN

DO YOU HAVE ANY PAIN(S)? Yes / No

AREA/DESCRIPTION OF SYMPTOMS	PAIN LEVEL: 0 TO 10	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Wheel of Balance Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area. For example, if you are extremely happy in your career, shade the entire pie shape for career. Do the same for each area, starting from the center point going outwards