Dr. Noelle King, ND

New Patient Health Information

Confidential Form

*We recognize all genders and identities. However, many insurance companies and legal entities do not. When working with you, we will always use the name and pronouns that you request, but be aware that the legal name and gender you have on file with your insurance company must be used on insurance and billing documents. **Questions marked with an asterisk* are required for insurance purposes, you may decline to answer all other questions if desired.**

Personal Information

		Today's Date (mm/dd/yyyy)
Name You Use		Pronouns
Legal Name*		DOB (mm/dd/yyyy)*
Mailing Address*		SSN*
Home Phone	Cell Phone	Other Phone (work, etc):
How Best to reach you? ❑ Home ❑ Cell ❑ Other	May we leave Medical Info Voicemail? ❑ Home ❑ Cell ❑ Other	May we leave Accounting Voicemail? ❑ Home ❑ Cell ❑ Other
Email		❑ Sign me up for your newsletter
Emergency Contact (EC) Name and Relationship to you		EC Number
Living Situation (Check all that apply)	❑ Alone ❑ With Partner ❑ With Partners	❑ With Children ❑ With Roommates ❑ With Elders/Extended Family
Occupation		❑ Full Time ❑ Part Time
Gender Identity	Legal Sex	Sex Assigned at Birth*
Current Relationship Structure		
Racial and/or Ethnic Identities (List all that apply):		

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Insurance Information

Primary Care Provider (PCP) Name		PCP Phone Number
Referral Source?		PCP Fax Number
Insurance Company Name*		
Insurance Subscriber ❑ Self ❑ Someone Else	NAME (If Someone Else)	DOB (If Someone Else)
Insurance ID Number*	Group Number*	Subscriber SSN
Secondary Insurance Company Name		
Secondary Insurance Subscriber ❑ Self ❑ Someone Else	NAME (If Someone Else)	DOB (If Someone Else)
Secondary Insurance ID Number	Group Number	Subscriber SSN

Current Health Information

How would you rate your current health	❑ Poor ❑ Moderate	❑ Good ❑ Excellent
What are your goals for today's visit?		
Please list your top health concerns, there is space for 5, but you may list more or less		
Concern	Treatments Already Tried	Results

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1)		
2)		
3)		
4)		
5)		
List Previous Diagnosis		Date Diagnosed
Do you have any special considerations or access needs that you want me to know about?		

Do you have any Allergies*? Please list, include the type of reaction*

List all current medications, hormones, supplements, vitamins, therapies etc (over the counter or prescribed)*		
Medication/Supplement	Dosage/Frequency	Reason For Taking

Personal Medical History

Please list any major accidents, injuries, surgeries, diseases or hospitalizations	
Event	Date

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List any Imaging, x-rays, CT scans, MRIs, etc (Include Reason)	Date

Family History - Check all that apply or leave blank if unknown. Feel free to ask for extra paper to include more family members

	Biological Parent 1	Biological Parent 2	Sibling 1	Sibling 2	Sibling 3 Or Child (circle)	Sibling 4 Or Child (circle)	Biological Grand-parent 1	Biological Grand-parent 2	Biological Grand-parent 3	Biological Grand-parent 4
Age (if living)										
Health (Good/Poor)										
Cancer										
Diabetes										
Heart Disease										
High Blood Pressure										
Stroke										
Epilepsy										
Mental Illness										

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Continued From Previous Page	Biological Parent 1	Biological Parent 2	Sibling 1	Sibling 2	Sibling 3 Or Child (circle)	Sibling 4 Or Child (circle)	Biological Grand-parent 1	Biological Grand-parent 2	Biological Grand-parent 3	Biological Grand-parent 4
Dementia										
Autoimmune										
Neurological disease (Alzheimer's, Parkinson's, MS)										
Asthma, Hay Fever, Hives										
Anemia										
Kidney Disease										
Glaucoma										
Tuberculosis										
Other										
Age at Death (if deceased)										
Cause of Death										

Review of Systems

Circle Y (Yes) P (Past) N (Never) for each category. Feel free to add anything not listed.

General Health		Significant changes in weight?	Y P N	**Exercise and Movement Habits**
Fatigue	Y P N	Sleep well?	Y P N	How often per week do you engage in movement practices?
Time of day Energy is		Average Hours per Night	________	
Lowest:	________	Do you Wake feeing Rested?	Y N	
Highest:	________	Rate Stress Level btwn		
Height:	________	1 (low) and 10 (high)	________	Tell me more about what you do:
Weight:	________			

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Food Intake		**Nose & Sinuses**		Frequent Urination	Y P N
What does your typical daily		Frequent Colds	Y P N	Frequency at Night	Y P N
menu look like?		Nose Bleeds	Y P N	Weak urine stream	Y P N
Breakfast		Sinus Problems	Y P N	Frequent UTIs	Y P N
____________________		Allergies / Hay Fever	Y P N	Kidney Disease	Y P N
Lunch				Kidney Stones	Y P N
____________________		**Mouth & Throat**		Prostatitis	Y P N
Dinner		Frequent Sore Throat	Y P N	Bedwetting	Y P N
____________________		Sore Tongue	Y P N		
Snacks		Gum Problems	Y P N	**Neurological**	
____________________		Hoarseness	Y P N	Fainting	Y P N
Beverages		Dental Cavities	Y P N	Seizures	Y P N
____________________				Muscle Weakness	Y P N
How often do you drink		**Chest & Lungs**		Numbness/Tingling	Y P N
caffeine/in what form?		Asthma	Y P N	Where ___________	
____________________		Bronchitis	Y P N	Memory Loss	Y P N
How much water do you drink		Pneumonia	Y P N	Disc Disease	Y P N
per day?		Emphysema/COPD	Y P N	Where __________	
____________________		Difficulty Breathing	Y P N	Carpal Tunnel	Y P N
How much alcohol do you drink		Pain on Breathing	Y P N	Cerebral Palsy	Y P N
per week?		Tuberculosis	Y P N	Parkinson's	Y P N
____________________		Chronic Cough	Y P N	Epilepsy	Y P N
Do you consume tobacco?	Y P	Sputum	Y P N	Multiple Sclerosis	Y P N
Do you use recreational drugs?	N	Spitting up Blood	Y P N	Paralysis	Y P N
	Y P	Wheezing	Y P N		
Head	N			**Musculoskeletal**	
Headaches		**Cardiovascular**		Joint Pain/Stiffness	Y P N
How often? _____________		Heart Disease	Y P N	Where ___________	
Circle: migraine / tension /	Y P	High Blood Pressure	Y P N	Arthritis	Y P N
cluster	N	Low Blood Pressure	Y P N	Type ____________	
Head Injury (Date __________)		Murmur	Y P N	Where ___________	
		Chest Pain	Y P N	Broken Bones	Y P N
Neck		Palpitations	Y P N	Which bones:	
Swollen Glands	Y P	Stroke	Y P N		
Lumps/Goiter	N	High Cholesterol	Y P N		
		Pacemaker/similar device	Y P N	______________	
Eyes				Muscle Spasms Aches	
Impaired Vision	Y P	**Peripheral Vascular & Blood**		Or Cramps	Y P N
Glasses/Contacts	N	Deep Leg Pain/Blood Clots	Y P N	Back Pain	Y P N
Double Vision	Y P	Swollen Ankles	Y P N	please circle:	
Eye Pain	N	Cold Hands/Feet	Y P N	upper / mid / lower	
Tearing, Dryness		Anemia	Y P N	Bursitis/Tendonitis	Y P N
Glaucoma		Easy Bleeding	Y P N	Joint Dislocation or	
Cataracts	Y P	Bleeding that won't stop	Y P N	Instability	Y P N
	N	Easy Bruising	Y P N	Which joint(s):	
Ears	Y P				
Loss of Hearing	N	**Genitourinary**		______________	
Ringing	Y P	Incontinence	Y P N	Scoliosis	Y P N
Earache	N	Pain on Urination	Y P N	Osteoporosis	Y P N
Dizziness/Vertigo	Y P	Blood in Urine	Y P N		
	N				
	Y P				

	N Y P N Y P N Y P N Y P N Y P N Y P N				

Gastrointestinal	
How often do you have bowel movements ______________	
Has this changed recently	Y P N
Constipation	Y P N
Diarrhea	Y P N
Diverticulitis	Y P N
Crohn's/Colitis	Y P N
Trouble Swallowing	Y P N
Heartburn	Y P N
Change in thirst/appetite (circle)	Y P N
Nausea/Vomiting	Y P N
Gas/Bloating/Belching	Y P N
Reflux/GERD	Y P N
Liver Disease	Y P N
Gall Bladder Disease/Stones	Y P N
Ulcer	Y P N
Hernia	Y P N
Hemorrhoids	Y P N
Endocrine	
Diabetes	Y P N
Thyroid Disorder	Y P N
Type ________________	
Heat/Cold intolerance	Y P N
Excessive Thirst/Hunger (circle)	Y P N
Night Sweats	Y P N
Skin	
Allergies/Rashes/Itching	Y P N
Dermatitis	Y P N
Eczema	Y P N
Acne	Y P N
Hives	Y P N
Boils	Y P N
Color Changes	Y P N
Lumps	Y P N
New or changed moles/marks	Y P N
Keloids/Scarring	Y P N
Infectious Skin Conditions	Y P N
Wounds that won't Heal	Y P N
Mental & Emotional	
Depression	Y P N
Anxiety	Y P N
High Stress Levels	Y P N
Trouble Sleeping	Y P N
Eating Disorder	Y P N
Mood Swings	Y P N
Little interest or pleasure in activities	Y P N
Feeling hopeless	Y P N
Feeling useless	Y P N
Thoughts of suicide or self-harm	Y P N
Trouble completing tasks	Y P N
Trouble getting along with people	Y P N
Do you have a relationship with a mental health care provider?	Y P N
Do you have a spiritual practice?	Y P N
Trauma History	
Have you had a traumatic event or events that may impact your comfort receiving care today?	Y N
Please share whatever you feel comfortable sharing at this time:	
Breast Tissue	
Self-Exams	Y P N
Lumps	Y P N
Tenderness/Pain	Y P N
Nipple Discharge	Y P N
Reproductive & Sexual Health	
Sexually Active	Y P N
Sex Partner has (circle all that apply) penis / vagina / other	
Body parts I use when having sex (circle all that apply) penis / vagina / anus	
Recent change in sex drive	Y P N
Infertility	Y P N
PMS/Cramps	Y P N
PCOS/Fibroids	Y P N
Prostate Disease	Y P N
Testicular Mass	Y P N
Pregnant (due date _________)	Y P N
Trying to conceive	Y P N
Number of the following	
Pregnancies ______	
Miscarriages ______	
Abortions ________	
Live Births ________	
STD/STI	Y P N
Which _____________	
Do you Menstruate	Y P N
# days of bleeding _______________	
Length of cycle _______________	
Bleeding btwn period	Y P N
Irregular cycles	Y P N
Painful menses	Y P N
Excessive Flow	Y P N
Unusual Genital Discharge	Y P N
Genital Sores	Y P N
Sexual Difficulties	Y P N
Pain with intercourse	Y P N
Birth Control methods	Y P N
What type _______________	
For how long _______________	
Menopause symptoms	Y P N
Which _______________	
Since When _______________	
Other Conditions	
HIV / AIDS	Y P N
Hepatitis	Y P N
Diabetes	Y P N
Type_____________	
Cancer	Y P N
Type ____________	
Autoimmune Condition	Y P N
Type ____________	
Dental Issues	Y P N
Dialysis	Y P N
Sleep Apnea	Y P N

Patient Signature	Date (mm/dd/yyyy)