

Naturopathic Women's HealthCare
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New Patient Intake

Personal Information

Name _____ Age _____
Sex Female Male Gender Identify as _____
Date of Birth ____/____/_____
Address _____ Apt. # _____
City _____ State _____ Zip _____
Phone (Day) _____ (Evening) _____ (Cell) _____
Is it OK to leave messages? Yes ___ No ___
Email address _____
Preferred contact Day phone Evening phone Cell phone Email

Emergency contact
Name _____
Relationship _____
Daytime Phone _____

Who may I thank for your referral?

Current Health Conditions

Conditions, symptoms, concerns - in order of priority	Date of onset
(1) _____	_____
(2) _____	_____
(3) _____	_____
(4) _____	_____
(5) _____	_____

How do these conditions affect your life?

NAME _____ AGE _____ Page 2

Medical History

Do you have a Primary Care Physician? No Yes

Dr. _____ Phone _____

Date of last physical exam _____

Have you consulted your PCP about the aforementioned condition(s)? No Yes

Have you consulted another practitioner about the aforementioned condition(s)? No Yes

If so, who? _____

Have you been to a Naturopathic Doctor before? No Yes

Dr. _____

Please state any previous diagnosis, treatment and results (any practitioner):

Please indicate if you have had the following conditions or symptoms by marking "C" for current, "P" for past or "N" for never:

C P N

- Anemia
- Anxiety or nervousness
- Arthritis
- Asthma
- Atherosclerosis
- Autoimmune disease
- Blood pressure problems
- Bone disease
- Breathing problems
- Cancer _____
- Chest pain
- Chronic inflammation
- Chronic pain
- Circulatory problems
- Cold sores
- Constipation
- Debilitating fatigue
- Dental problems
- Depression
- Diabetes Type _____
- Diarrhea
- Difficulty breathing
- Difficulty sleeping
- Dizziness or fainting
- Ear infections
- Eating disorder
- Feel unsafe at home

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“C” for current, “P” for past or “N” for never:

C P N

- Frequent antibiotic use
- Frequent colds or flu
- Gallbladder disease
- Gastrointestinal disorder
- Hay fever
- Headaches
- Head injury
- Heartburn
- Heart disease
- Hemorrhoids
- Hypoglycemia
- Irritable Bowel Syndrome
- Kidney disease
- Liver disease
- Loss of appetite
- Lyme disease
- Memory loss
- Mononucleosis
- Mood swings
- Nausea
- Neurological disease
- Numbness / tingling
- Osteoporosis
- Panic attacks
- Parasites
- Physical abuse
- Seizures
- Sinus problems
- Skin problems
- Stroke
- Substance abuse
- Thyroid problems
- Ulcers
- Vaccinations Routine Only
- Varicose veins
- Vomiting
- Other _____

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Gynecological History

Are you pregnant now? Yes No

Age menses began _____ Date of last menstrual period ____ / ____ / _____

Number of pregnancies _____ Number of births _____

Last Pap smear ____ / ____ / _____

Last mammogram ____ / ____ / _____

Describe your periods (If you are no longer having periods, describe what your typical cycle was like):

Average number of days in cycle _____

Cycles are Regular Irregular

Average number of days of bleeding _____

Periods are Light Medium Heavy Painful

PMS No Yes: _____ days per month

Please indicate if you have had the following conditions or symptoms by marking "C" for current, "P" for past or "N" for never:

C P N

Abnormal Pap smear

Breast pain or lump

Changes in sex drive

Changes in memory

Changes in mood

Desire pregnancy

Dry skin

Endometriosis

Facial hair

Frequent/chronic yeast infections

Hair loss

Hormone replacement therapy

Hot flashes

Hysterectomy

Impaired fertility

Please list any known allergies:

Drug _____

Environmental _____

Food _____

Other _____

Family History

Mother Health problems: _____

Alive Deceased at age ____ ; Cause of death _____

Father Health problems: _____

Alive Deceased at age ____ ; Cause of death _____

