INNATE
wellness & medical center

Gemie M. McLeod, NMD
Licensed Naturopathic Medical Doctor

820 Ainsworth Drive, Suite B
Prescott, AZ 86301
928.776.1600 Office
928.778.5264 Fax
info@innatewellnessaz.com
innatewellnessaz.com

REGISTRATION FORM

PATIENT INFORMATION		
Name	Phone Number (s)	Date of Birth
	Primary Alternate	
Address	City	State, Zip Code

Occupation	Employer	Employer Phone Number
Marital Status (circle one)	Email Address	How did you hear about us?
Single/ Mar/ Div/ Sep/ Wid		

CONTACT METHODS
It may be valuable or necessary for this office or your doctor to contact you via phone or email. If you provided an email address to our office, reminder emails regarding upcoming appointments will be sent. Please choose the following options regarding other means of contact:
( ) Yes, IWMC may leave me a voicemail related to my care at Primary or Alternate number (circle one)
( ) Yes, IWMC may email me related to my care
( ) NO, I do NOT want any messages or emails in addition to the automatic reminder email

IN CASE OF EMERGENCY		
Name of local relative or friend	Relationship to Patient	Contact Number

PATIENT SIGNATURE
By signing below, I am acknowledging the following: the above information is true and correct to the best of my knowledge; I am financially responsible for any balance due at the time of service; I have received and understood the Insurance Billing Policy; I have received and understood the Notice of Privacy Practices in regards to the Health Insurance Portability & Accountability Act of 1996 (HIPAA); I will receive appointment reminder emails if I have provided an email address above; I will abide by the office policy regarding cancellations.
_____ _____ Patient/Guardian Signature Date

MEDICAL HISTORY

How committed are you towards making valuable life changes? (circle one)

LITTLE MODERATELY VERY

Please list your chief concerns in order of decreasing severity, starting with the worst one:

Concern/Problem	Date of Onset	Frequency (if applicable)	Severity

Please list date of last complete blood work and ordering Physician:

FAMILY HISTORY

	Father		Mother		Siblings		Grandparents		Spouse		Children	
Age (if living)												
Age at death & cause												
Cancer/type												
Hypertension	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Heart Attack	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Stroke	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Heart Disease	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Asthma/Allergies	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Mental Illness	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

Tuberculosis	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Auto-Immune Disorder	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Diabetes/Type	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

List all surgeries and hospitalizations with date:

Please note when and why you have had the following:

X-Rays

MRI/CT Scans

Ultrasounds

Accidents

TB Test

Last Dental Visit

HIV

Last Eye Exam

Please list current and past diagnoses, onset or diagnosis date, and treatments:

Diagnosis	Onset or Diagnosis Date	Treatment

Have you been exposed to the Disease (D), Immunization (I), or Neither (N)? Circle your response:

Measles	D	I	N	Chicken Pox	D	I	N	Rubella	D	I	N
Tetanus	D	I	N	Whooping Cough	D	I	N	Haemophilus (Hib)	D	I	N
German Measles	D	I	N	Mumps	D	I	N	Hepatitus B	D	I	N

Vaccination Reactions:

Regarding use of the following, please circle Yes (Y), No (N), or Past (P):

Antacids	Y	N	P	Steroids	Y	N	P	Smoking	Y	N	P	Packs/day & Years
Analgesics	Y	N	P	Laxatives	Y	N	P	Coffee	Y	N	P	Cups/day Past & present
Soda Pop	Y	N	P	Oz./day				Alcohol	Y	N	P	How much & how often
Alcohol Treatment	Y	N	P	Recreational Drugs	Y	N	P	Drug Addictions	Y	N	P	Drug Treatment

When you drink caffeinated beverages, do you find it difficult to handle the effects from caffeine?

List all prescription medication and nutrient supplements/herbs that you are taking and include dosage, if known.

REVIEW OF SYSTEMS

Present Weight: Weight one year ago: Height: Ideal Weight:

Regarding the next section:

If you answer YES and you have the problem now, circle "Y"
If you answer NO, and you have never had the problem, circle "N"
If you have had the problem in the Past, circle "P"

Good Energy: Y N P

Fatigue: Y N P

If you have fatigue, when is it the worst – morning, afternoon, evening (circle one)

If you have fatigue, can you do what you need to during the day? Y N

Circle Energy LeveL: (0= no energy – 10 = most energy) 1 2 3 4 5 6 7 8 9 10

SKIN

Rash	Y	N	P		Color Changes	Y	N	P
Hives	Y	N	P		Lump	Y	N	P
Psoriasis/eczema	Y	N	P		Itchy	Y	N	P
Dry	Y	N	P		Warts/Moles	Y	N	P
Cancer	Y	N	P		Perspiration	Y	N	P

HEAD						
Headache	Y	N	P	Migraine	Y	N	P
Dandruff	Y	N	P	Head Injury	Y	N	P
Oily/Dry Hair	Y	N	P	Hair Loss	Y	N	P

NOSE						
Frequent Colds	Y	N	P	Nosebleeds	Y	N	P
Congestion	Y	N	P	Post Nasal Drip	Y	N	P
Polyps	Y	N	P	Seasonal Allergies	Y	N	P

EYES						
Dry/Watery	Y	N	P	Blurry Vision	Y	N	P
Double Vision	Y	N	P	Cataracts	Y	N	P
Glaucoma	Y	N	P	Styes	Y	N	P
Eye Strain	Y	N	P	Discharge	Y	N	P
Itchiness	Y	N	P	Dark under Eyelids	Y	N	P

MOUTH & THROAT						
Canker Sores	Y	N	P	Cold Sores	Y	N	P
Sore Throat	Y	N	P	Gum Disease	Y	N	P
Root Canals	Y	N	P	Amalgam fillings	Y	N	P
Loss of Taste	Y	N	P	Hoarseness	Y	N	P

NECK						
Stiffness	Y	N	P	Swollen Glands	Y	N	P
Full Movement	Y	N	P	Tension	Y	N	P

RESPIRATORY						
Cough	Y	N	P	Tuberculosis (TB)	Y	N	P
Shortness of breath with exertion	Y	N	P	Bronchitis	Y	N	P
Shortness of breath sitting	Y	N	P	Pneumonia	Y	N	P
Shortness of breath lying down	Y	N	P	Asthma	Y	N	P
Wheezing	Y	N	P	Painful breathing	Y	N	P

CARDIOVASCULAR						
High Blood Pressure	Y	N	P	Rheumatic Fever	Y	N	P
Low Blood Pressure	Y	N	P	Murmurs	Y	N	P
Arrhythmia	Y	N	P	Palpitations	Y	N	P
Edema	Y	N	P	Chest Pain	Y	N	P

URINARY TRACT

Incontinence	Y	N	P		Pain with urination	Y	N	P
Frequent Infections	Y	N	P		Kidney Stones	Y	N	P
Urgency	Y	N	P		Discharge/Blood	Y	N	P

GASTROINTESTINAL

Heartburn	Y	N	P		Bowel Movement Frequency:	Y	N	P
Indigestion	Y	N	P		Recent BM change	Y	N	P
Bloating	Y	N	P		Diarrhea or Constipation	Y	N	P
Nausea	Y	N	P		Hemorrhoids	Y	N	P
Vomiting	Y	N	P		Gallbladder Disease	Y	N	P
Change in appetite	Y	N	P		Liver Disease	Y	N	P
Pancreatitis	Y	N	P		Ulcer	Y	N	P
Colonoscopy Date:	Y	N	P					

Please list any food allergies:

FEMALE

Age Menses began				Frequency of Menses (i.e., every 28 days)			
Length of Menses in days				Heavy menstrual bleeding/clots	Y	N	P
PMS	Y	N	P	Menstrual Pain	Y	N	P
Last menses date				Food Cravings	Y	N	P
Last Pap Smear				Times pregnant			
Abnormal Paps	Y	N	P	How many births			
Date of abnormal paps				Abortions	Y	N	P
Diagnosis of abnormal pap:				Menopause since what age			
Vaginitis	Y	N	P	Types of Hormones used			
Sexually active	Y	N	P	Dry Vaginal Tissue	Y	N	P
Sexually Transmitted Infections	Y	N	P	Pain with Intercourse	Y	N	P
Mammography	Y	N	P	Healthy libido	Y	N	P
If yes, list date & results				DEXA Scan	Y	N	P

List any birth controls used and ages used				

MUSCULOSKELETAL

Weakness	Y	N	P		Arthritis	Y	N	P
Stiffness	Y	N	P		Leg Cramps	Y	N	P
Tremors	Y	N	P		Pain	Y	N	P

NERVOUS SYSTEM

Paralysis	Y	N	P		Sciatica	Y	N	P
Tingling/Numbness	Y	N	P		Carpal Tunnel Syndrome	Y	N	P
Seizures	Y	N	P		Fainting	Y	N	P

MENTAL/EMOTIONAL

Depression	Y	N	P		Anger/Irritability	Y	N	P
Suicidal	Y	N	P		High strung/tense	Y	N	P
Anxiety	Y	N	P		Fear/Panic	Y	N	P
Eating Disorder	Y	N	P		Psych Hospitalization	Y	N	P

History of sexual, mental/emotional, or physical abuse: Y N

If so, at what age and by whom:

EXERCISE

How often do you exercise? **What type of exercise?**

For how long? **Hobbies:**

DIET

Please list a typical daily dietary intake:

Breakfast	
Lunch	

Dinner	
Snacks	
Dessert	
Fluids	

SLEEP

How many hours per night? If you frequently wake, what is the reason?

Nightmares: Y N P Wake Refreshed: Y N P Must day nap: Y N P

Sleep walk: Y N P Grind Teeth: Y N P Snore: Y N P

TOXIN EXPOSURE

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?

Have you recently put new carpeting in your home, painted your home, installed new cabinets or did other refurbishing?

Are you particularly sensitive to perfumes, gasoline, or other vapors?

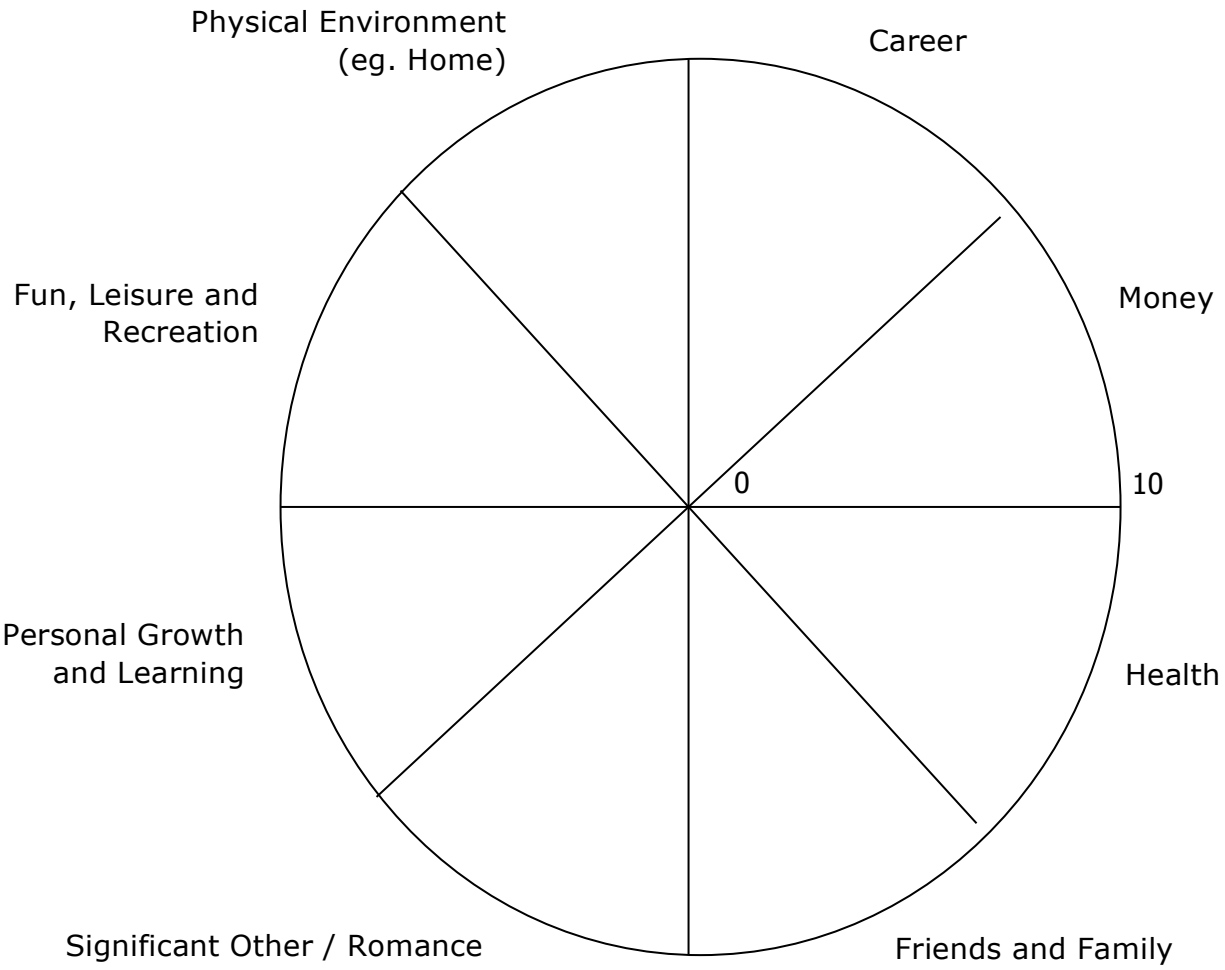
Do you use pesticides, herbicides other chemicals around your home?

Please provide any additional comments or insights in the space below:

What is your expectation, goal, or desire from this initial appointment with Dr. Gemie?

WHEEL OF LIFE

NAME: _____ **DATE:** _____



WHEEL OF LIFE INSTRUCTIONS

The 8 sections in the Wheel of Life represent balance.

- Please change, split or rename any category so that it's meaningful and represents a balanced life for you.
- Next, taking the center of the wheel as 0 and the outer edge as 10, rank your **level of satisfaction** with each area out of 10 by drawing a straight or curved line to create a new outer edge (see example)
- The new perimeter of the circle represents **your** 'Wheel of Life'. Is it a bumpy ride?

EXAMPLE