



Northern Virginia Natural Health

2212 Mt. Vernon Ave, 2nd Floor Suite
Alexandria, VA 22301

NEW CLIENT REGISTRATION FORM

All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them during your visit.

PATIENT INFORMATION / PROFILE

Name:	Date of Birth:	Gender:
Address:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Other	
City: State: Zip:	Number of people in household: children?	
Occupation:	Employer / School:	
Social Security No.:		
Education completed:	<input type="checkbox"/> High School	<input type="checkbox"/> Some College <input type="checkbox"/> College <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other
Travel Outside US?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where / When?

MINORS ONLY

Mother's Name:	Biological mother?
Father's Name:	Biological father?
What is the relationship status and living situation of the child's mother and father?	
Others who may be bringing your child in for medical care (name and relationship):	

CONTACT INFORMATION

Phone Numbers:	<input type="checkbox"/> Phone (work):	<input type="checkbox"/> Phone (home):	<input type="checkbox"/> Phone (cell / pager):
Check the box next to the number (s) where we can leave a private message that may contain confidential health information			
Email:	Would you like to be included on our email list? Y N		
Name of Spouse or Partner:			
Name(s) and age (s) of Children:			
Emergency Contact :	Home phone:		
Relationship to patient:	Work phone:		

Referrals and Adjunctive Care

Are you currently under medical care?	<input type="checkbox"/> No <input type="checkbox"/> Yes	For:
Please list other health care professionals from whom you receive care (name, specialty, contact # if possible):		
How did you find NVNH?		
Who is your Primary Care Physician (PCP)? Clinic Name, Address and phone:		
Have you ever consulted with or been treated by a naturopathic physician, acupuncturist, chiropractor, nutritionist or massage therapist before?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? Who? (circle those that apply)



Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

What long-term expectations do you have from working with our clinic?

What is your present level of commitment to address any underlying causes to your signs and symptoms that relate to your lifestyle? (Rate from 0-10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behavior or lifestyle habits do you currently engage in regularly that you believe support your health (please list)?

What behavior or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits (please list)?

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?



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Surgeries, Hospitalizations, Major Illnesses

Remember to include illnesses such as mono, Lyme disease, etc, as well as all surgical procedures, including cosmetic procedures

Age	Procedure or Condition	Any Ongoing Issues Related to this?
Do you any have drug allergies or life-threatening allergies?		

Personal and Family Medical History

	Self	Mother	Father	Grandmother		Grandfather		Sibling 1	Sibling 2	Child
				Mother's side	Father's side	Mother's side	Father's side			
Age (if living)										
Health: G=good, F=fair, P=poor										
Age at death										
Cause of death										
Please check all that apply:										
Alcohol/drug addiction										
Allergies										
Alzheimer's or dementia										
Asthma										
Autoimmune disease										
Cancer (specify type)										
Celiac disease										
Colitis/Crohn's										
Depression										
Diabetes										
Eczema										
Epilepsy										
Heart disease										
High blood pressure										
High cholesterol										
Kidney disease										
Liver disease										
Mental illness (specify)										
Stroke										
Thyroid (hyper/hypo)										
Other (specify)										

Is there anything else you would like me to know?

