Katherine Reinholtz, N.D.
NATUROPATHIC MEDICINE

917-791-0730 (NYC)
540-230-6758 (VA)
DrKatherineND@gmail.com
www.KatherineReinholtzND.com

NEW PATIENT INFORMATION AND HEALTH HISTORY FORM

Name: _____

Age:_____Date of Birth:_____Gender: Male / Female (circle)

Contact Information (**please circle the preferred number for contacting you**)

Address: _____

City: _____State: _____ Zip:_____

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

Email address: _____

☐ May Dr. Reinholtz to leave messages at your preferred number regarding appointments and medical care?

Marital Status: ☐ Married/partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ In a relationship

With Whom do you live? ☐ Spouse/Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Occupation: _____Hours per week: _____

Employer :_____Are you Satisfied with your job?_____

Emergency Contact:_____Relationship:_____

Emergency Contact Phone Number:_____

How did you hear about this clinic? _____

Are you currently receiving healthcare? Yes / No If **Yes**, please provide Contact Information

Name of Provider/Clinic_____

Address_____

If **No,** When and where did you last receive medical care? _____

_____

PERSONAL HEALTH HISTORY

1.) What are your primary health care concerns? List as many as you can in order of importance.

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle)

Cancer	Heart Disease	High Blood Pressure	Epilepsy
Arthritis	Glaucoma	Tuberculosis	Stroke
Kidney disease	Anemia	Mental Illness	Diabetes
Asthma	Hay fever	Hives	

Any other relevant family history? _____

CHILDHOOD ILLNESSES

Please circle whether you had any of the following as a child:

Rheumatic fever	Diphtheria	Scarlet fever
Chicken pox	Measles	Mumps

HOSPITALIZATIONS, SURGERY, IMAGING

Please list any hospitalizations, surgeries, X-Rays, CAT Scans, MRI's, EEG's, EKGS, or other procedures that you may have had.

_____Year_____

_____Year_____

_____Year_____

_____Year_____

_____Year_____

_____Year_____

ALLERGIES

Are you hypersensitive of Allergic to.....
Any Drugs?_____

Any Foods?_____

Any Environmentals or Chemicals?_____

CURRENT MEDICATIONS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

GENERAL

Height:_____Weight:_____ lbs. Weight 1 year ago:_____ lbs.

Maximum Weight :_____lbs. When: _____

When during the day is your energy the best?_____ worst? _____

TYPICAL FOOD INTAKE

Breakfast:_____

Lunch: _____

Dinner:_____

Snacks:_____

To drink:_____

REVIEW OF SYSTEMS

Please circle Y =Yes, condition you have now P = Problem of the past N = No, never had the problem

Main interests and
Hobbies?_____

Do you Exercise?	Y N		
If Yes, What kind?_____		How Often?_____	
How many hours of sleep do you get?			
Sleep Well?	Y N	Enjoy your work?	Y N
Wake Rested?	Y N	Take Vacations?	Y N
Have a supportive relationship?	Y N	Spend time outside?	Y N
Any history of Abuse?	Y N	Watch television?	Y N
Any major traumas?	Y N P	How Many hours/day?_____	
Use recreational drugs?	Y N P	Read?	Y N
Been treated for drug dependence?	Y N P	How many hours/day?_____	
Use Alcoholic Beverages?	Y N P	Do you eat 3 meals per day?	Y N
How many per week?_____		Do you go on Diets often?	Y N
Been treated for Alcoholism?	Y N P	How often do you eat out?_____	
Do you use Tobacco?	Y N P	Do you drink coffee?	Y N
How many years?_____		Do you drink soda?	Y N
How many packs/day?_____			
Do you have a religious or spiritual practice?	Y N	If yes, what?_____	

Mental / Emotional

Treated for emotional problems?	Y N P	Tension?	Y N P
Depression?	Y N P	Poor Concentration?	Y N P
Mood Swings?	Y N P	Memory problems?	Y N P
Anxiety or nervousness?	Y N P	Considered/attempted suicide?	Y N P

Immune

Reactions to immunizations?	Y N P	Chronic infections?	Y N P
Reactions to vaccinations	Y N P	Chronically swollen glands?	Y N P
Chronic Fatigue syndrome?	Y N P	Slow wound healing?	Y N P

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne/boils?	Y N P	Itching?	Y N P
Color changes?	Y N P	Perpetual Hair loss?	Y N P
lumps?	Y N P	Night Sweats?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	TMJ/Jaw problems?	Y N P

Ears

Impaired hearing?	Y N P	Dizziness?	Y N P
Ringing in ears?	Y N P	Ear aches?	Y N P

Eyes

Impaired vision?	Y N P	Color blindness?	Y N P
Cataracts?	Y N P	Tearing or dryness?	Y N P
Glaucoma?	Y N P	Eye pain or strain?	Y N P
Spots in vision?	Y N P	?	Y N P

Nose and Sinus

Frequent colds?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P
nosebleeds?	Y N P		

Neck

Lumps in Neck?	Y N P	Goiter?	Y N P
Difficulty swallowing?	Y N P	Pain or stiffness in Neck?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Teeth grinding?	Y N P
hoarseness?	Y N P	Gum problems?	Y N P
Jaw clicks/TMJ?	Y N P	Dental cavities?	Y N P

Respiratory

Cough?	Y N P	Shortness of breath?	Y N P
Sputum?	Y N P	Pain with breathing?	Y N P
Asthma?	Y N P	Emphysema?	Y N P
Wheezing?	Y N P	Tuberculosis?	Y N P
Bronchitis?	Y N P	Coughing up blood?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Ulcers?	Y N P
Change in thirst?	Y N P	Jaundice?	Y N P
Change in appetite?	Y N P	Gall bladder disease?	Y N P
Nausea/vomiting?	Y N P	Liver disease?	Y N P
Hemorrhoids?	Y N P	Pancreatitis?	Y N P
Heartburn?	Y N P	Abdominal pain or cramping?	Y N P
Belching and/or passing gas?	Y N P	Bloating?	Y N P
Diarrhea?	Y N P	Constipation?	Y N P

Bowel movement: how often?_____

Is this a change?_____

Black stools?	Y N P	Blood in stools?	Y N P

Urinary

Increased frequency of urination?	Y N P	Frequency at night?	Y N P
Inability to hold urine?	Y N P	Frequent UTI's?	Y N P
Pain with urination?	Y N P	Kidney stones?	Y N P
Chronic kidney disease?	Y N P	Interstitial cystitis?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Weakness?	Y N P
Arthritis?	Y N P	Muscle spasms or cramps?	Y N P
Broken bones?	Y N P	Osteoporosis/Osteopenia?	Y N P

Blood

Anemia?	Y N P	Thrombophlebitis?	Y N P
Easy bleeding or bruising?	Y N P	Varicose veins?	Y N P
Deep leg pain?	Y N P		

Male Reproductive System

Hernias?	Y N P	Prostatitis?	Y N P
Testicular masses?	Y N P	Prostate Cancer?	Y N P
Testicular pain?	Y N P	Discharge or sores?	Y N P
Benign Prostatic Hypertrophy ?	Y N P	Sexually transmitted diseases?	Y N P
Are you sexually active?	Y N P	Premature ejaculation	Y N P
Erectile dysfunction?	Y N P	Herpes?	Y N P

Female Reproductive System

Age of first menses _____ Date of last menses _____

Length of cycle _____ Duration of menses _____

Date of last annual exam _____ Result_____

Painful menses?	Y N P	Endometriosis?	Y N P	Ovarian cysts?	Y N P
Heavy flow?	Y N P	Fertility Issues?	Y N P	Cervical dysplasia?	Y N P
Tender breasts?	Y N P	Cycles regular?	Y N P	Venereal diseases?	Y N P
Sexually active?	Y N P	Bleeding between cycles?	Y N P	Abnormal pap?	Y N P
Sexual difficulty?	Y N P	PMS?	Y N P	Menopausal symptoms?	Y N P
Nipple discharge?	Y N P	Breast lump(s)?	Y N P	Do self breast exams?	Y N P

Birth control? Y N P If yes, what type? _____

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____Number of abortions _____

LIFESTYLE

1.) What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

2.) What behaviors or lifestyle habits do you currently engage in that you believe are **self-destructive?** How often do you engage in these activities?

3.) What do you **love** to do with your time?

4.) What long term expectations and goals do you have from working with Dr. Reinholtz?

5.) What expectations do you have of me personally as your doctor?

6.) Is there anything else you would like me to know in order to better serve you?

Thank you for your time and effort. Dr. Katherine Reinholtz looks forward to providing you with the best possible care!