Dr. Andrea Sullivan
Center for Natural Healing

PATIENT PROFILE

Date _____

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Age _____ Date of Birth _____ Birthplace _____

Email Address _____

Social Security number (Responsible Party) _____

Occupation _____

Employer _____

Address _____

City _____ State _____ Zip _____

Referred By _____

PERSON TO CONTACT IN CASE OF EMERGENCY

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

LIST HEALTH PROBLEMS/COMPLAINTS IN ORDER OF IMPORTANCE

1 _____ 3 _____

2 _____ 4 _____

Is this Condition due to injury for sickness arising out of your employment? ☐ Yes ☐ No

Have you had similar symptoms before? ☐ Yes ☐ No If So, When?

Have you seen a Physician for the above Conditions? ☐ Yes ☐ No If So, When?

Date of last Complete Physical Exam _____

MEDICAL HISTORY

Current Medications

1 _____ 3 _____

2 _____ 4 _____

Nutritional Supplements, Herbs

1 _____ 3 _____

2 _____ 4 _____

Serious Illnesses _____

Major Accidents _____

INDICATE APPROXIMATE AMOUNTS BELOW

	Never	Occasionally	Weekly	Daily
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Drugs (Recreational	_____	_____	_____	_____
Aspirin	_____	_____	_____	_____
Supplements	_____	_____	_____	_____
Antacids	_____	_____	_____	_____

Do you use a Special Diet_____

Do you react to Certain Foods, Pollens or Animals? If so, List them Below:

1 _____ 3 _____

2 _____ 4 _____

List any Chemicals, Metals, Dusts or Fumes you are exposed to regularly ans how you react to them.

How Frequently have you taken Antibiotics?

FAMILY HISTORY

Please indicate if any and which of family members have had any of the following condition(s)

Allergies_____ Thyroid Disorder _____

Alcoholism_____ High Blood Pressure _____

Asthma_____ Hypoglycemia_____

Cancer _____ Kidney Disease_____

Diabetes_____ Nervous or Mental Disorder_____

Epilepsy _____ Tuberculosis _____

Heart Disease _____ Other Inheritable Condition_____

Have you had any of the Above?_____ Which?_____

YOUR HEALTH HISTORY

Please indicate if any and which of family members have had any of the following condition(s)

Back Trouble _____ Loss Of Sex Drive _____

Cataracts _____ Rheumatic Fever _____

Gall Bladder Disorder _____ Scarlet Fever _____

Colitis/Diverticulitis _____ Skin Problems _____

Insomnia_____ Hearing Loss _____

Liver Disease _____ Visual Disorder_____

Venereal Disease _____ Cancer_____

(GONORRHEA, SYPHILIS, HERPES, WARTS ETC.)

WOMEN:

Menstrual Cycle Regular? _____ Length of Cycle? _____

Are You Pregnant? _____ Number Of Pregnancies? _____ Births?_____

Miscarriages? _____ Abortions? _____

Have You Ever Used Birth Control Pills? _____ Dates? _____

When Was Your Last Pap Smear?_____ Results? _____

Do You Experience Premenstrual Symptoms?_____

What Are They And How Severe? _____

HISTORY OF VACCINATIONS (FOR CHILDREN ONLY):

_____

_____

I UNDERSTAND THAT MY INSURANCE COMPANY MAY NOT REIMBURSE FOR THE EXPENSES INCURRED AT THIS OFFICE. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL DEBT.

PERSON PAYING FOR THE BILL (if not patient) _____

SIGNATURE_____ DATE _____

I understand a 24 hour advanced notice is required when canceling my appointment and if there is not a 24 hour notice given, I will be billed $55.00 for a late cancellation fee.

SIGNATURE_____ DATE _____

I understand that if i do not keep my appointment and do not call to cancel or reschedule, I will be billed $65.00 for a no show fee.

SIGNATURE_____ DATE _____