

Dr. Frank Aieta

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Dear Patient: Please **PRINT and FILL OUT** this questionnaire and bring it with you for your appointment on:

_____ at _____ AM/PM.

PATIENT INFORMATION FORM

Name _____ Date of First Visit _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home) _____ (work) _____ (Cell) _____

E-Mail address _____

Age _____ Date of Birth _____ Sex: Female _____ Male _____

Social Security Number _____

Married ___ Separated ___ Divorced ___ Widowed ___ Single ___ Partnership ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___

Student Status: ___ Non-student ___ Part-time ___ Full-Time ___

School Name _____

Occupation _____ Hrs per week _____ Retired _____

Employer _____ Work address _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

In case of emergency contact _____

Relationship _____ Phone# _____

Address _____

HEALTH HISTORY QUESTIONNAIRE

Have you ever received naturopathic care, if yes with whom and when?

Please List Specific Health Concerns in **Order of Importance** to you:

1. _____

Date Began _____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this (y/n) _____

If yes, what medications or treatments were given _____

2. _____

Date Began _____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this (y/n) _____

If yes, what medications or treatments were given _____

3. _____

Date Began _____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this (y/n) _____

If yes, what medications or treatments were given _____

Do you have any opinions regarding what may have **caused** your health concerns?

How much effort are **you** willing to put into getting better?

NONE 0 1 2 3 4 5 6 7 8 9 10 **WHATEVER IT TAKES**

Do you have any known **contagious diseases** at this time? (y/n)

If yes, what? _____

Allergies (Medicine, Food, Environmental) _____

Please list any **hospitalizations or surgeries** with **dates**: _____

Please indicate: **SELF** or a **RELATIVE** have experienced any of the following:

YES	WHO	YES	WHO
Alcoholism	_____	Hemophilia	_____
Allergies	_____	High Blood Pressure	_____
Anemia	_____	High Cholesterol	_____
Arthritis	_____	Mental Health Condition	_____
Asthma	_____	Migraines	_____
Auto immune Disorder	_____	Obesity	_____
Cancer	_____	Osteoporosis	_____
Depression	_____	Other Addiction	_____
Diabetes	_____	Psoriasis	_____
Eczema	_____	Seizures	_____
Glaucoma	_____	Fibrocystic breast	_____
Gout	_____	Stroke	_____
Hay fever	_____	Suicide Attempt	_____
Heart Attack	_____	Thyroid Disorder	_____
Heart Disease	_____		

CURRENT MEDICATIONS

Do you take or use? Please Check all that apply.

Laxatives ___ Pain relievers ___ Antacids ___ Cortisone ___ Appetite suppressants ___ Antibiotics _____

Tranquilizers ___ Thyroid medication ___ Sleeping pills _____

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please indicate any of the following:

Smoke _____ How long _____ Number/Day _____

Alcohol _____ Type _____ How often: _____

Caffeine _____ What drink _____ How often: _____

Sugar _____ How much _____ How often: _____

Artificial Sweetener _____ Type _____ How often: _____

Exercise _____ Type _____ How often: _____

Food Cravings _____ What _____ How often: _____

Sleep Problems _____ Type _____ How often: _____

Weight Changes _____ Gain/Loss _____ When: _____

Diet Restrictions _____ What: _____

Which of the following **treatments** are you interested in specifically:

Homeopathy _____ Spinal Manipulation _____ Acupuncture _____ Nutritional Counseling _____
No preference _____

If one of your health concerns was fatigue you may want to read Dr. Aieta's article on fatigue and fill out, print and bring with you to your first visit a fatigue questionnaire.

Click here to read the article: [WHY AM I SO TIRED?](#)

Click here to print out a fatigue questionnaire: [ADRENAL FATIGUE QUESTIONNAIRE](#)

I hereby allow my health insurance company to reimburse Dr. Frank Aieta directly for services rendered by this office. I understand and agree to pay, in a timely manner, any fees not covered or denied by my insurance company, including co-payments and annual deductibles.

SIGNATURE _____ DATE _____

