



Dr. Travis J. Elliott

NATUROPATHIC PHYSICIAN

Full Legal Name: _____ / _____ / _____
(Last Name) (First Name) (Middle Initial)

Preferred Name: _____ Age: _____ Date of Birth: _____ S.S.#: _____

Address: _____ / _____ / _____ / _____
(street#/PO Box) (city) (state) (Zip code)

Telephone # () _____ / () _____ / () _____
(home) (work) (cell phone or other)

E-mail address: _____ Gender: female _____ male _____

Are you (check one): Single _____ Married _____ Other _____ Partner's Name: _____

Occupation: _____ (circle) Full time/ Part time /Student/ Retired

Employer / School: _____

Address: _____ / _____ / _____ / _____
(Street / PO Box) (City) (State) (Zip code)

How did you hear about Dr. Elliott? _____

Emergency Contact _____
(Name) (Relationship)

() _____ () _____
(Day Phone) (Evening Phone)

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).

Is there any place you do **NOT** want me to leave a message? _____

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

May Dr. Elliott email you with a monthly newsletter and/or other educational material? Yes No

Please rate the following statements from 1-10, depending on **how strongly you agree**. (There is no right answer! ☺)
1. My health and disease are primarily a product of my mind. (circle one) 1 2 3 4 5 6 7 8 9 10
2. My mind can only do so much; it is important to take the right supplements and medicines for optimal health.
(circle one) 1 2 3 4 5 6 7 8 9 10

Insurance Information – Please provide copy of front and back of Insurance card.
Do you have any secondary or additional Insurance plans? Yes No **Name:** _____

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient _____ Today's Date _____

Name: _____

Date of Birth: _____

What are the concerns for which you are seeking care? (Primary concern first)

1. _____ Date of onset: _____

2. _____ Date of onset: _____

3. _____ Date of onset: _____

4. _____ Date of onset: _____

Who is your primary care physician? _____
(Name) (Phone if known)

For what concern did you last receive health or medical care? _____

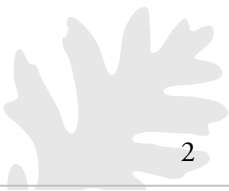
Do you have any known contagious diseases at this time? Yes No If yes, what? _____

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current health							
Age at death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer _____ Diabetes _____ Epilepsy _____
Heart Disease _____ High Blood Pressure _____ Stroke _____
Anemia _____ Kidney Disease _____ Glaucoma _____
Allergies _____ Asthma _____ Mental Illness _____
Arthritis _____ Tuberculosis _____ Alzheimer's Dz _____



Name: _____

Date of Birth: _____

Have you have any of the following Childhood Illnesses (check if yes)

Scarlet fever ____ Diphtheria ____ Rheumatic fever ____ Mumps ____ Measles ____ German measles ____

Have you had any immunizations? Yes No Negative Reactions? _____

Hospitalizations, Surgery, X-Ray and Special Studies

Please list the parts of your body for which you have been hospitalized, had surgery, x-rays, or other special studies?

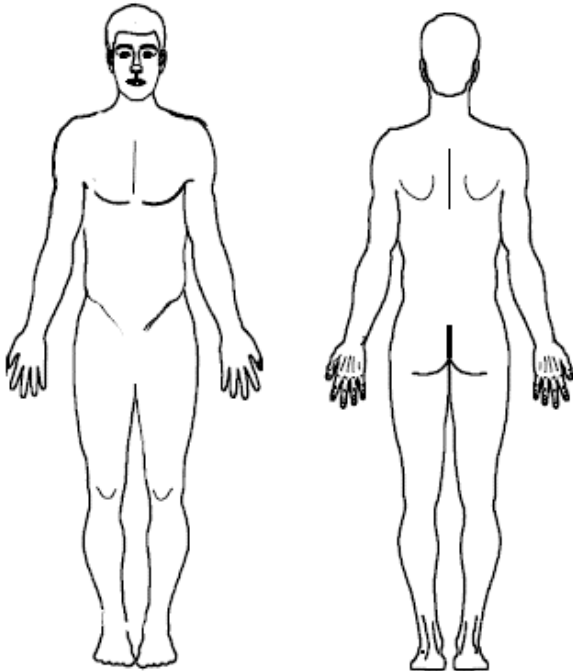
Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

General

Weight _____ lbs. Height _____
Maximum (non pregnant) Weight _____ lbs.

Weight 1 year ago _____ lbs.
When _____

Please shade in areas where you are experiencing pain on figures (if applicable).



LIFESTYLE HABITS

Main interests and hobbies? _____

Exercise, what kind? _____

How often do you exercise? _____

Y N Have a religious/spiritual practice

Y N Average 6-8 hrs. of sleep

Y N Have a supportive relationship

Y N History of abuse

Y N Major traumas

Y N Use recreational drugs

Y N Treated for drug dependence

Y N Drink coffee

Y N Drink black or green tea

Y N Drink cola or other sodas

Y N Add salt to your food

Y N Eat refined sugar

Y N Enjoy your work

Y N Take vacations

Y N Spend time outside

Y N Watch TV? How much? _____

Y N Read? How often? _____

Y N Use alcoholic beverages
per week _____

Y N Treated for alcoholism

Y N Use tobacco currently

Y N Used tobacco in the past
How many years? _____
How many packs per day? _____



