Dr. Valeria Breiten, ND RD **Arnica Natural Health LLC**
www.DrValeria.net Valeria@DrValeria.net

Patient Name ______________________ **Date** __________

Address ______________ **City** ____________ **State** _____ **Zip** ________

Work Phone ____________ **Home Phone** ____________ **Cell Phone** __________

Occupation ______________________ **Email** ______________________

Referred By ______________________ **Age** __________

Chief Complaint ______________________ **Date of Birth** __________

Related Family Members & Relationship to you	Age or Age died	Health & Illnesses

Have you or any family members (siblings, parents, grandparents) ever had any of the following?:

DISEASE	SELF	FAMILY MEMBER	DISEASE	SELF	FAMILY MEMBER
Alcohol/Drug Abuse	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Allergies	[ ]	[ ]	Liver or Gall Bladder	[ ]	[ ]
Anemia	[ ]	[ ]	Mental Illness/Severe Depression	[ ]	[ ]
Asthma	[ ]	[ ]	Migraine/Severe Headaches	[ ]	[ ]
Bronchitis	[ ]	[ ]	Pneumonia	[ ]	[ ]
Cancer (type)	[ ]	[ ]	Sexually Transmitted Disease	[ ]	[ ]
Diabetes	[ ]	[ ]	Stroke	[ ]	[ ]
Eczema	[ ]	[ ]	Tuberculosis	[ ]	[ ]
Epilepsy/Seizures	[ ]	[ ]	Ulcers	[ ]	[ ]
Heart Disease	[ ]	[ ]	Urinary Tract Infection	[ ]	[ ]
Other	[ ]	[ ]	______________________		

Prior Surgery/Hospitalization ______________________ **Date** __________

______________________ **Date** __________

______________________ **Date** __________

Current Medications/Herbs/ Vitamins ______________________

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Please turn over for page 2

DO YOU	Yes	No	How Much?
Drink Coffee	[ ]	[ ]	Cups/day __________
Smoke	[ ]	[ ]	Packs/day __________ # of Years _________ When stopped
Drink Alcohol	[ ]	[ ]	Drinks/day __________ Type _______________
Aspirin use	[ ]	[ ]	Number per week ____________
Exercise	[ ]	[ ]	Times per week ____________ Length of Time ____________

Have You Had Previous Homeopathic Treatment? ___________________________________

For What Condition? ___________________________________

Are You Currently Under the Care of a Physician? ___________________________________

For What Condition? ___________________________________

Immunizations ____

Reactions ____

Drug Reactions or Allergies ____

Living Situation Alone _________ Parents __________ Partner/Spouse _________

Friends _________ Other _________________________________

Children Number _________ Currently living with you ____________

Domestic Violence Past_______________ Current____

Other problems ____

____

Genitourinary Problems
(Problems with your urinary tract or reproductive organs, including infections and sexually transmitted diseases.)

Problem ____ Date ____________________

Problem ____ Date ____________________

Menstrual History

Number of days in cycle? _____ How many days flow? _____ Age at first period? _____ Spotting between periods? _____

Pain or other problems? **Pregnancy History** Number of live births? _____ Number of pregnancies? _____

Insurance Information: **Provider**_____________________ Primary Insured__________________________________
Patient Relation to insured: self spouse or child Insured's Date of Birth ____________ Employer ______________________
Group ____________________________ ID #_____________________
Patient assumes financial responsibility for bill if insurance does not reimburse.
Signature_______________________________________ Date _____________________________

I _________________________________, give my consent for Dr. Valeria Breiten, NMD and her associates:

- To collect information about my medical history.
- To perform and order physical and diagnostic exams including laboratory and x-rays.
- To diagnose and treat within the standard scope of practice as defined by the Arizona Naturopathic Board of Medical Examiners and Arizona state law.

Neither claims of cure nor promises have been made regarding the outcome of my therapy.
With my signature below, I affirm that all information within this document is complete, accurate and true to the best of my knowledge.

Signature ____ **Date** ____________________