Dr. Kristen Bishop and Dr. Judith Ziol
Naturopathic Medical Doctors

New Patient Paperwork

Patient Name:_____ Date:_____Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home phone: _____Work Phone:_____Cell Phone:_____

Occupation:_____Employer_____Hours work per week:_____

Email _____ Preferred method for contact_____

Marital Status (circle):Single Married Separated Divorced With Partner Widow(er)

Insurance Company:_____Policy:_____Group #:_____

Name of Insured_____ Their date of birth_____
Relation to Insured_____

Person to call in case of Emergency:_____Relationship to you:_____

Phone number contact for them:_____

Other Physicians you see and their specialty:
_____
_____

List in Order of Importance what your problems are:

1.
2.
3.
4.
5.

Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	____	_____	_____	_____	_____
Age when died	_____	____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

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

Please List All Sensitivities/Allergies/Reactions

Drugs: _____
Foods: _____
Environment: _____

List Yes, No, or Past regarding use of the following:

Antacids: Y N P Steroids: Y N P
Smoking: Y N P Packs per day if Yes/Past:_____
Analgesics: Y N P Laxatives: Y N P
Coffee: Y N P Cups per day if Yes/Past:_____
Alcohol: Y N P How often and how much if Yes/Past:_____
Any alcohol addiction: Y N P
Recreational drugs: Y N P

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

_____

_____

_____

_____

_____

_____

Review Of Systems:

Present Weight:_____ Height: _____ Ideal Weight:_____

Good Energy: Y N
Fatigue: Y N
If you have fatigue, when in morning, afternoon, evening is it the worst?:_____

Skin:

Rash:	Y N	Color Change:	Y N
Hives:	Y N	Lump:	Y N
Psoriasis/eczema:	Y N	Itchy:	Y N
Dry:	Y N	Warts/moles:	Y N
Cancer:	Y N	Perspiration:	Y N

Head:

Headache:	Y N	Migraine:	Y N
Dandruff:	Y N	Head Injury:	Y N
Oil/dry hair:	Y N	Hair loss:	Y N

Eyes:

Dry/Watery:	Y N	Blurry vision:	Y N
Double vision:	Y N	Cataracts:	Y N
Glaucoma:	Y N	Styes:	Y N
Strain:	Y N	Discharge:	Y N
Itchy:	Y N	Dark under eyelid:	Y N

Nose:

Frequent colds:	Y N	Nosebleeds:	Y N
Congestion:	Y N	Post nasal drip:	Y N
Polyps:	Y N	Seasonal allergies:	Y N

Mouth/Throat

Canker sores:	Y N	Cold sores:	Y N
Sore throat:	Y N	Gum disease:	Y N
Dentures:	Y N	Cavities:	Y N
Loss of taste:	Y N	Hoarseness:	Y N

Neck:

Stiffness:	Y N	Swollen glands:	Y N
Full movement:	Y N	Tension:	Y N

Respiratory:

Cough:	Y N	TB:	Y N
Shortness of breath with exertion:	Y N	Bronchitis:	Y N
Shortness of breath sitting:	Y N	Pneumonia:	Y N
Shortness of breath lying down:	Y N	Asthma:	Y N
Wheezing:	Y N	Painful breathing:	Y N

Cardiovascular:

High blood pressure:	Y N	Rheumatic Fever:	Y N
Low blood pressure:	Y N	Murmurs:	Y N
Arrhythmias:	Y N	Palpitations:	Y N
Edema:	Y N	Chest pain:	Y N

Gastrointestinal:

Heartburn:	Y N	Bowel movement frequency:_____	
Indigestion:	Y N	Recent change in BM:	Y N
Bloating:	Y N	Diarrhea or constipation:	Y N
Nausea:	Y N	Hemorrhoids:	Y N
Vomiting:	Y N	Gall bladder disease:	Y N
Change in Appetite:	Y N	Liver disease:	Y N
Pancreatitis:	Y N	Ulcer:	Y N

Urinary Tract:

Incontinence:	Y N	Pain with urination:	Y N
Frequent infections:	Y N	Kidney stones:	Y N
Urgency:	Y N	Discharge/blood:	Y N

Male Genitalia:

Testicular pain/swelling:	Y N	Sexually active:	Y N
Hernia:	Y N	Sexually transmitted disease:	Y N
Discharge:	Y N	Prostate disease/symptoms:	Y N
Impotency:	Y N	Sexual orientation:	Hetero Homo Bi

Female Genitalia:

Age periods began:_____
How long periods last: _____
Periods:
Heavy Bleeding: Y N
Cramping: Y N
Pain: Y N
PMS: Y N
Food Cravings: Y N
Last Pap Smear:_____
Last menstrual cycle _____
Any abnormal paps: Y N

How often periods occur:_____
Menopausal since what age:_____
Times Pregnant:_____
How many births:_____
Miscarriages:_____
Abortions:_____
Sexual Active: Y N
Healthy Libido: Y N
Pain With Intercourse: Y N
Dry Vagina: Y N
Vaginitis: Y N

Any Birth Control (please list types and ages used):_____
Sexually Transmitted Diseases: Y N
Mammography: Y N
Bone Density Scan: Y N If Yes, what were the results:_____
Use of Hormone Replacement Therapy: Y N

Musculoskeletal:

Weakness: Y N
Stiffness: Y N
Tremors: Y N

Arthritis: Y N
Leg cramps: Y N
Pain: Y N

Nervous:

Paralysis: Y N
Tingling/numbness: Y N
Seizures: Y N P

Sciatica: Y N
Carpal tunnel syndrome: Y N
Fainting: Y N

Mental/Emotional:

Depression: Y N
Suicidal: Y N
Anxiety: Y N

Anger/irritability: Y N
High-strung/tense: Y N
Fear/Panic: Y N

Exercise:

How often:_____
What type(s):_____
For How long:_____

Hobbies:

_____

_____

Sleep:
How long per night: _____
If you wake up frequently, what is the reason: _____
Nightmares: Y N
Wake refreshed: Y N
Must Nap during the day: Y N
Grind Teeth: Y N
Snore: Y N

Toxin Exposure:
Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:_____
Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:_____
Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_____
Are you particularly sensitive to perfumes, gasoline, or other vapors?:_____
Do you use pesticides, herbicides, other chemicals around your home?_____
_____

Social Life:
Enjoy job?: Y N
Active Spiritual practice: Y N
History of sexual, mental/emotional, physical abuse?: Y N

How committed are you towards making valuable changes: Little Moderately Very

I look forward to partnering with you to help you achieve your healthcare goals!
In health,
Dr. Bishop and Dr. Ziol

Keystone
NATURAL FAMILY MEDICINE

Authorization for Release of Protected Health Information Records

Patient Legal Name _____Date of Birth_____

Address_____ Phone #_____

City_____ State_____ Zip Code_____

□ I hereby authorize (your current Doctor's full name, address and phone number)_____
_____
_____

To disclose protected health information of the person listed above to (check one):

_____Dr. Kristen Bishop _____ Dr. Judith Ziol
____ Dr. Leah Collier _____ Dr. Brent Cameron

Keystone Natural Family Medicine
10153 East Hampton
Suite 104
Mesa, AZ 85209
(480) 535-5688

PLEASE FAX RECORDS TO (480) 535-5689

Type of access requested (copies of the records):
_____ Entire record from _____
_____ Lab work
_____ Imaging
_____ Other_____

□ I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
□ I have read the above and authorize the disclosure of the protected health information.

Signature of Patient/Legal Representative_____
Date:_____