

**THE NEW LIFE CENTER**  
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**ADULT HEALTH HISTORY FORM**

Date of 1st Appointment. _____
Name _____ Gender: M ___ F ___ Birth Date _____ Age _____
Name you wish to be called _____ Marital Status: _____ Height _____ Weight _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile Phone _____
Email Address _____ Social Security Number _____
Education _____ Occupation _____ Position _____
Who is the nearest relative or friend who you would like to have called in case of an emergency?
Name _____ Relationship: _____ Phone: _____
How Did You Learn About The New Life Center / Dr. Alvarado? _____

Please list what you want to achieve by coming to The New Life Center:

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What problems, difficulties, illnesses, or complaints would you like remedied?

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Have you ever been to a  Naturopathic Physician  Acupuncturist  Other "Natural Practitioner"

Do you have a pacemaker, artificial heart valve, or any artificial device in your body?  Yes  No

If yes, please describe: \_\_\_\_\_

What is your level of mental stress?  low  moderate  high

What is the pace of your work?  slow  medium  fast

Please check any below that have been a problem for a parent, grand-parent, sister or brother:

- |                                    |                                   |  |  |  |
|------------------------------------|-----------------------------------|--|--|--|
| <input type="checkbox"/> cancer    | <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke          | <input type="checkbox"/> heart problems          | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> celiacs  | <input type="checkbox"/> mental disorder | <input type="checkbox"/> alcoholism/addiction    | <input type="checkbox"/> thyroid/adrenal     |
| <input type="checkbox"/> asthma    | <input type="checkbox"/> epilepsy | <input type="checkbox"/> kidney disease  | <input type="checkbox"/> autoimmune or inherited | _____  |

Please check any of the following you are exposed to:

- |                                    |                                   |   |   |
|------------------------------------|-----------------------------------|---|---|
| <input type="checkbox"/> dust      | <input type="checkbox"/> mold     | <input type="checkbox"/> dampness       | <input type="checkbox"/> fumes          |
| <input type="checkbox"/> chemicals | <input type="checkbox"/> paint    | <input type="checkbox"/> solvents       | <input type="checkbox"/> insecticides   |
| <input type="checkbox"/> varnishes | <input type="checkbox"/> lacquers | <input type="checkbox"/> excessive heat | <input type="checkbox"/> excessive cold |

What is your current energy level? (1=low; 5=high)      1            2            3            4            5

Do you have any contagious disease?    Yes    No    If yes, please describe:

\_\_\_\_\_

Are you receiving any care for physical well-being now? If so from whom? \_\_\_\_\_

For what purpose? \_\_\_\_\_

Are you receiving any care for emotional well-being now? If so from whom? \_\_\_\_\_

For what purpose? \_\_\_\_\_

Were you happy as a child?    Yes    No    What fostered or prevented your happiness?

\_\_\_\_\_

\_\_\_\_\_

Are you happy now?    Yes    No    What fosters or prevents your happiness now?

\_\_\_\_\_

\_\_\_\_\_

Please rate the quality of the following different parts of your life (1=low; 5=high):

Family	1	2	3	4	5
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Friends	1	2	3	4	5
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Romance/relationship(s)	1	2	3	4	5
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Spirituality	1	2	3	4	5
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Health	1	2	3	4	5
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Recreation/fun	1	2	3	4	5
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Career	1	2	3	4	5
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Financial	1	2	3	4	5
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Physical Environment

___Where you live	1	2	3	4	5
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___Where you work	1	2	3	4	5
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___Other	1	2	3	4	5
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Please list, using 1 or 2 words each, the five or ten things you personally value most in life. They may be ideals, emotions, objects, attitudes, situations, behaviors, skills, abilities or anything else, whatever you value most. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In the boxes on the far left of this list, please check the **Past** or **Now** columns for past and current issues.

Past	Now	Please leave this space blank.			
		Please leave this space blank.			
		Please leave this space blank.			
		Please leave this space blank.			
		Please leave this space blank.			
		Please leave this space blank.			
		Please leave this space blank.			
		Please leave this space blank.			
		Please leave this space blank.			
		Please leave this space blank.			
		Head injury			
		Headaches			
		Migraine headaches			
		Earaches			
		Excess ear wax			
		Impaired hearing			
		Ringing in ears			
		Blurry or double vision			
		Eye pain/strain			
		Cataract			
		Glaucoma			
		Eye tearing			
		Eye dryness			
		Spots in vision			
		Eye injury			
		Excess saliva			
		Dry mouth			
		Gum problems			
		Teeth-grinding			
		Root canal(s)			
		Jaw/TMJ problems			
		Difficulty swallowing			
		Mouth sores			
		Asthma			
		Bronchitis			
		Cough			
		Breathing difficulty			
		Breathing pain			
		Short of breath			
		Wheezing			
		Spitting up blood			
		Emphysema			
		Pleurisy			
		Tuberculosis			

Past	Now	Please leave this space blank.			
		Pneumonia			
		Allergy / Hay fever			
		Sinus infection / problems			
		Frequent colds/flu/sore throat			
		Neck lump(s)			
		Chest pain			
		Angina			
		Heart disease			
		Heart murmur			
		Heart palpitations			
		Irregular heart beat			
		Fast heart beat			
		Slow heart beat			
		High blood pressure			
		Low blood pressure			
		Stroke			
		Blood clots			
		Ankle swelling			
		Cold hands or feet			
		Deep leg pain			
		Easy bruising			
		Varicose veins			
		Arthritis			
		Joint pain			
		Broken bone(s)			
		Shoulder pain			
		Arm pain			
		Elbow pain			
		Wrist pain			
		Hand pain			
		Hip pain			
		Leg pain			
		Knee pain			
		Ankle pain			
		Foot pain			
		Neck pain			
		Upper back pain			
		Lower back pain			
		Sciatica			
		muscle twitching			
		Muscle spasms or cramps			
		Fibromyalgia			
		Osteoporosis			

Past	Now	Please leave this space blank.			
		Stomach problems			
		Digestive problems			
		Intestinal problems			
		Bowel problems			
		Irritable bowel syndrome			
		Colitis			
		Crohn's disease			
		Diarrhea			
		Constipation			
		Hemorrhoids			
		Blood in stool			
		Black stool			
		Ulcer			
		Abdominal pain/cramps			
		Appendicitis			
		Bloating/gas			
		Heartburn			
		Change in appetite			
		Nausea/vomiting			
		Fatigue after meals			
		Pancreatitis			
		Jaundice			
		Hepatitis			
		Other Liver disease			
		Gall bladder disease			
		Painful urination			
		Frequent urination - day			
		Frequent urination - night			
		Difficulty starting urination			
		Difficulty continuing urination			
		Weak urinary stream			
		Urinary "dribbling"			
		Incontinence			
		Urinary tract infections - UTI's			
		Kidney stones			
		Other Kidney disease			
		Thyroid problem			
		Goiter - swollen thyroid			
		Adrenal problem			
		Pituitary problem			
		Fatigue / tiredness			
		Hypoglycemia			
		Diabetes			
		Excessive thirst			

Past	Now	Please leave this space blank.			
		Sensitive to cold			
		Sensitive to heat			
		Hair loss			
		Night sweats			
		Hot flashes			
		Hormonal problems			
		Other endocrine problems			
		<b>Male Issues</b>			
		Testicular problems			
		Prostate problems			
		Inguinal hernia			
		Impotence			
		Premature ejaculation			
		Discharges or sores			
		Decreased Libido			
		Sexual difficulty or pain			
		Sexually transmitted infection			
		Painful Intercourse			
		<b>Female Issues</b>			
		Irregular menstrual cycles			
		Painful menses			
		Heavy menstrual flow			
		Medium menstrual flow			
		Light menstrual flow			
		Blood clots in menses			
		Bleeding between menses			
		Cervical dysplasia			
		Abnormal PAP			
		Ovarian cyst(s)			
		Sexual difficulty or pain			
		Sexually transmitted infection			
		Pelvic inflammatory disease			
		Premenstrual syndrome (PMS)			
		Breasts tender			
		Breast lump(s)			
		Nipple discharge			
		Vaginal itching			
		Vaginal discharges or sores			
		Difficulty conceiving			
		Endometriosis			
		Painful intercourse			
		Decreased Libido			
		Hot flashes			
		Other menopausal symptoms			



Please **CHECK** all the questions below which are true for you and **CIRCLE** any that are more relevant.

- Were you raised by both parents?  
If not, who raised you? \_\_\_\_\_
- Did you receive kindness, love, and attention from them?
- Did you do things together just for fun?
- Did you get along well with:
  - your parent(s) or guardian?
  - our sibling(s)?
  - your schoolteachers?
  - your classmates?
- As a child did anyone in your family have a problem with alcohol, drugs, or addictions?
- Was anyone mentally or physically abusive?
- Was there a particular family member who was especially kind and loving?
- Were you happy as a child?
- Are you happy now?
- Have you been married more than once?
- Do you get along well with your partner?
- Do you enjoy being with your partner?
- Do you do things together just for fun?
- If you have children, what are their ages?  
\_\_\_\_\_
- Do you get along well with all of them?
- Do you enjoy being with all of them?
- Do you do things together just for fun?
- How many people live in your house? \_\_\_\_\_
- Have you or has anyone in your home
  - been mentally or physically abusive?
  - been addicted to drugs or alcohol?
  - been especially kind & loving to you?
- Are you kind and loving to your family and friends?
- Do you do something daily for your own enjoyment?
- Do you spend significant time outside?
- Do you have hobbies or similar interests?  
please list \_\_\_\_\_
- Do you enjoy your work?
- Do you have more than one job?
- How many hours do you work weekly? \_\_\_\_\_
- Do you get along well with
  - your employer?
  - our fellow employees?
  - people you supervise?
  - your friends?
- Do you consider your health to be good?  
Do you:
  - exercise regularly?
  - awaken rested?
  - have regular bowel movements?
  - have a satisfactory sex life?
  - have a vacation each year?
  - watch TV? - how much? \_\_\_\_\_
  - drink alcohol - how much? \_\_\_\_\_
  - use recreational drugs? how often \_\_\_\_\_
  - drink coffee - how much? \_\_\_\_\_
  - use birth control?
    - pills
    - other
  - use tobacco?  
how much \_\_\_\_\_ how long \_\_\_\_\_



## Appointments and Payment

We have found it is best to be sure that everyone is clear about appointment and payment policies before their first appointment. The policies are simple. This note is to insure your understanding. If you have any questions or concerns please call The New Life Center and we will answer them for you.

Your first appointment at The New Life Center will be approximately 2.5 hours. The fee is \$185. Future visits will be approximately 1 to 1½ hour and the fee is \$95. Nutritional supplements and herbal remedies, etc. are charged separately. If for any reason you are unable to keep an appointment please give us as much notice as possible. If you can't keep your appointment, call at least 24 working day hours before your appointment, or you will be responsible for full payment. (call on Friday by 10:00 AM if you can't keep a Monday 10:00 AM appointment, etc. – weekends and national holidays are not working days) We regret that past experience has made this policy necessary.

Full payment is due at the time services are rendered. Should this ever not be possible, please make specific financial arrangements with us *prior* to your visit. We do not routinely send bills for services. If your insurance company covers our services the invoice/receipt you receive from us will have the information your insurance company needs to reimburse you. We cannot accept payment directly from insurance companies. If you have any questions please call us and we will be happy to answer them .

Thank you again for coming to The New Life Center. We appreciate and value the privilege of serving you and will do our best to help you receive the assistance you need and deserve.

Please sign and date this form and mail or fax it to us along with your Health History Form.  
Thank you.

I have read and agree to the information and policies described above.

Name (please print) \_\_\_\_\_

Signature\_\_\_\_\_ Date\_\_\_\_\_