

**THE NEW LIFE CENTER**  
**Gil Alvarado, N.D., L.Ac., Dipl.Ac.(NCCAOM)**  
**118-A Old Durham Road, Chapel Hill, NC 27517**  
**(919) 490-4930; fax (919) 882-9455**

**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 _____	
Nearest Relative or Friend Who May be Called in Case of an Emergency:			
Name _____		Hm.Ph. _____	Wk.Ph. _____
Who Told You 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 received treatment from a Naturopathic Physician \_\_\_ Acupuncturist \_\_\_ Other "Natural Practitioner" \_\_\_

Do you have a pacemaker, artificial heart valve, or any other artificial or metal 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 circle any of the following a family member has had:** Cancer; Diabetes; Heart/circulatory problems; Epilepsy; Nervous or mental disorder; Asthma; Arthritis; Thyroid or Adrenal problems; Inherited disease \_\_\_\_\_

**Please circle any of the following you are exposed to:**

dust	fumes	chemicals	paint/solvents
insecticides	varnishes/lacquers	excessive heat	excessive cold

**Please UNDERLINE any of the following you have experienced in the past,  
AND  
Please CIRCLE any of the following which you have recently or are currently experiencing:**

- |  |   |                     |                     |                      |
|--|---|---------------------|---------------------|----------------------|
| arthritis / joint pain   | bone / joint disease                              | jaundice            | hepatitis           | stroke               |
| migraines  | chronic candidiasis                               | diabetes            | cancer              | high blood pressure  |
| venereal disease   | asthma  | skin condition      | low blood pressure  | cold sweats          |
| head injury  | broken bones                                      | back pain           | neck pain           | major injury         |
| weight change  | chronic fatigue                                   | muscle twitching    | mononucleosis       | appendicitis         |
| food, chemical, or drug poisoning  |   | enlarged glands     | abnormal discharges | abnormal bleeding    |
| unusual lumps  | loss of balance                                   | abnormal sensations | eye pain / tearing  | headaches            |
| ringing ears   | nosebleeds  | short of breath     | chest pain          | irregular heart beat |
| difficulty swallowing  | stomach, digestive, intestinal, or bowel problems |                     | food intolerances   | mouth sores          |
| urinary frequency, urgency, dribbling, or difficulty starting or retaining |   |                     | kidney problems     | osteoporosis         |
| fear   | anxiety   | panic               | nervousness         | nervous breakdown    |
| compulsiveness   | extreme stress                                    | extreme pain        | suicidal thoughts   | confusion            |
| grief  | guilt   | shame               | loneliness          | depression           |
| poor concentration   | irritability                                      | low self-esteem     | lack of confidence  | trembling            |
| goiter   | thyroid problems                                  | adrenal problems    | genital sores       | painful intercourse  |
| <b>Male:</b>   | testicular problems                               | prostate problems   | impotence           | inguinal hernia      |
| <b>Female:</b>   | uterine problems                                  | ovary problems      | pre-menstrual synd. | vaginitis            |
| menopause  | breast lumps                                      | miscarriage(s)      | cervicitis          | pelvic inflammatory  |

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Age at 1st menstruation\_\_\_\_\_

Is your flow ( ) light ( ) medium ( ) heavy

Last menstrual Period(date)\_\_\_\_\_

Have you ever had an abortion(s)\_\_\_\_\_

Do you have menstrual pain\_\_\_\_\_

Date of last PAP\_\_\_\_\_Results\_\_\_\_\_

Length of period(flow)\_\_\_\_\_

Do you have hot flashes\_\_\_\_\_

Length of cycle(monthly)\_\_\_\_\_

Are you pregnant\_\_\_\_\_Possibly Preg.\_\_\_\_\_

Do you have any other illness, health problem or comments?

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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?

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

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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.**

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

- |  |   |
|--|---|
| – Were you raised by both parents?                         | – Do you get along well with your partner?              |
| – If not, who raised you?_____                             | – Do you enjoy spending time with your partner?         |
| – Did you receive kindness, love, and attention from them? | – Do you do things together just for fun?               |
| – Did you do things together just for fun?                 | – If you have children, what are their ages?_____       |
| – Did you get along well with:                             | – Do you get along well with all of them?               |
| – your parent(s) or guardian?                              | – Do you enjoy spending time with all of them?          |
| – your sibling(s)?   | – Do you do things together just for fun?               |
| – your schoolteachers?                                     | – How many people live in your household?_____          |
| – your classmates?   | – Have you or has anyone in your home (now or recently) |
| – When you were a child did anyone in your family          | – been mentally or physically abusive?                  |
| have a problem with alcohol, drugs, or addictions?         | – had a problem with alcohol, drugs, or addictions?     |
| – Was anyone mentally or physically abusive?               | – been especially kind and loving to you?               |
| – Was there a particular family member                     | – Are you kind and loving to your family, and friends?  |
| who was especially kind and loving?                        | – Do you do something daily for your own enjoyment?     |
| – Were you happy as a child?                               | – Do you enjoy your work?                               |
| – Are you happy now?                                       | – Do you have more than one job?                        |
| – Have you been married more than once?                    | – About how many hours do you work each week?_____      |

- Do you get along well with
  - your employer?
  - your fellow employees?
  - people you supervise?
  - your friends?
- Do you consider your health to be good?
- Do you:

- exercise regularly?
- awoken rested?
- have regular bowel movements?
- have a satisfactory sex life?
- have a vacation at least once each year?
- drink alcoholic beverages (how much?\_\_\_\_\_)
- drink coffee (how much?\_\_\_\_\_)
- use birth control? (pills\_\_\_\_\_other\_\_\_\_\_)
- use tobacco (how much?\_\_\_\_\_how long?\_\_\_\_\_)

– Are you aware of having any allergies?

Please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

– Do you follow any special way of eating?

Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

– Have you ever been hospitalized or had surgery?

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all prescribed medication, over-the-counter medication, vitamin and food supplements, herbs, and any other supplements or remedies which you are using now. Please indicate what you are using them for, how much you use, and how long you have been using them. Thank You.

What you use	What it's for	How much used	How long used

Thank you for taking the time to complete this form. It will help me to help you. I look forward to meeting with you.

Gil Alvarado, ND, LAc

*The New Life Center*

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 hours. The fee is \$145. Future visits will be approximately 1 to 1½ hour and the fee is \$85. 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 if you can't keep a Monday 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 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 The Center and we will be happy to answer them for you.

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 \_\_\_\_\_