North Star Naturopathic Medicine

The Medical Practice of Dr. Christina Caselli, ND – Mount Shasta, California

Patient Information

Name	DOB	Gender M_____ F _____
	Email Would you like to be on our email list: Y_____ N_____	

Address	Home Phone
	Mobile Phone

Emergency Contact

Name Relationship to you Phone

Preferred way to receive correspondence and messages: Mobile Phone_____ Home Phone_____ E-mail_____

Is it okay to receive text and/or email appointment reminders: Y_____ N_____

Have you seen a doctor that practices natural or integrative medicine before? Yes____ No____
If so, what type of natural medicine-oriented clinicians have you visited?

Naturopathic Doctor_____ Holistic MD/DO_____ Acupuncturist_____ Chiropractor_____ Other:_____

Do you have health insurance? Yes_____ No_____
If Yes, HMO or PPO? Who is your insurance carrier?

Please list other health care providers you are currently working with:

Name	Specialty	Contact Info
1.		
2.		
3.		

Current Health Concerns

Please list by order of importance to you. (Attach another list if necessary)	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe:
1.		
2.		
3.		

Phone: 530-925-3221
Fax: 1-888-974-1834
DrC@NorthStarMedicine.com
www.NorthstarMedicine.com
PO Box 554
Mt. Shasta, CA 96067

Drug Allergies

Any known medication allergies? Yes_____ No_____

If Yes, which medications:

What allergic reaction symptoms do you experience?

Past Medical History

Please list any hospitalizations and any major past illnesses or injuries (e.g., broken bones, surgeries, etc.):

Prescribed medications and over the counter medications – attach a separate list if necessary

Medication Name	Dose	When started?	Why?
1.			
2.			
3.			
4.			
5.			

Supplements – please list all vitamins/botanicals, homeopathics, etc.

Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started?	Why?
1.			
2.			
3.			
4.			
5.			

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Personal & Family Diagnosed Health Conditions	YES	Who? Indicate self or a specific family member	Notes:
ADD/ADHD	❑		
Alcohol/Drug Addiction	❑		
Anemia	❑		
Alzheimer's/Dementia	❑		
Arthritis (Osteo or Rheumatoid?)	❑		
Asthma	❑		
Autoimmune Diseases	❑		
Blood Disorder	❑		
Cancer	❑		What kind? Age diagnosed?
Cardiovascular Disease	❑		
Depression	❑		
Diabetes Type 2	❑		
Diverticulosis	❑		
Eating Disorder	❑		
Eczema	❑		
Epilepsy/Seizure Disorder	❑		
Fibromyalgia	❑		
Gallstones/Gall Bladder Disease	❑		
Gout	❑		
High Cholesterol	❑		
HIV/Aids	❑		
Hypertension	❑		
Inflammatory Bowel Disease	❑		
Kidney Disease	❑		
Learning Disability	❑		
Liver Disease - If Yes, specify:	❑		
Mental illness – If Yes, specify:	❑		
Neurologic disorder	❑		
Osteopenia/Osteoporosis	❑		
Stomach or Duodenal Ulcers	❑		
Stroke	❑		
Thyroid Disease	❑		
Other:	❑		

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