EDGEWATER
NATURAL FAMILY MEDICINE

22 Wilson Ave
Suite 205
St Cloud, MN 56304
P) 320-253-4112
F) 320-253-4116
www.edgewatermed.com

510 22nd Ave E
Suite 202B
Alexandria, MN 56308
P) 320-219-6800
F) 320-219-6801

Patient Update

Date_____

LEGAL INFORMATION

Patient's Legal Name _____Nick Name_____

Birthdate _____-_____-_____ Age_____ Male _____ Female _____

Parent or Legal Guardian Name _____

Address_____

City_____ State _____ Zip Code _____

Home Phone _____-_____-_____ Alternate or work phone _____-_____-_____

Email Address_____

Permanent Address if different from above (ex: college students)_____

City_____ State _____ Zip Code_____

MEDICAL INFORMATION

Your MD physician's name _____ Phone _____-_____-_____

Clinic Name _____

Your chiropractor's name _____ Phone _____-_____-_____

Clinic Name _____

HEALTH HISTORY

What is the main reason for seeing the doctor today? If there is a specific health condition, please describe it in detail, including the first time you noticed the condition. Please list any factors you suspect may have played a role in its onset and continuation.

_____

_____

_____

_____

How long has the main problem been an issue?

_____

List in order of importance other health problems that are an issue (please use back of page if more room is needed)

1._____

_____

_____

2._____

_____

_____

3._____

_____

_____

Allergies

Do you have known allergies to any drugs, foods, animals, herbs or other substances? Please list allergen and the reaction to it:

_____

_____

Medications

Please list all current pharmaceutical medicines you are currently taking

Name	Strength	Dosage	Indication	How long?

***Continue to list others at the end of this form if you need more room**

Repeated Use of (circle) antibiotics steroid laxatives

Vitamins or Herbs

Please list all current vitamins, herbs, homeopathics, and supplements you are currently taking

Name	Strength	Dosage	Indication	How long?

***Continue to list others at the end of this form if you need more room**

Sleep

How many consecutive hours per night do you sleep? _____Naps?_____

Is it a sound sleep or restless sleep? _____Do you wake refreshed or tired/irritable? _____

Do you wake easily or difficult? _____

Any sleep walking, sleep talking, or nightmares/terrors? _____

Is there anything else we need to know?

_____
_____
_____
_____
_____
_____
_____