Name: ____ Date: _______________

Address: ____

City: __________________ State: ________ Zip: ____________

Telephone: (H) (____)____-_______ (C) (____)____-_______ (W) (____)____-_______

Email: ____

☐ Check this box if you would like to receive our newsletter by email

☐ Male ☐ Female Age: ___________ Date of Birth: _________________

Marital Status: _______________________________ Number of Children: ________

Who were you referred by for your appointment today? ________________________

List your symptoms and concerns:

1. ____
2. ____
3. ____
4. ____
5. ____

Vitamins and Supplements

List all vitamins/minerals/herbal supplements you are currently taking:

____

____

____

Medications

List all prescription and non-prescription medications you are currently taking:

____

____

Medical History

List any major illnesses, injuries and/or surgeries that you have had and when:

____

____

____

Allergies

Do you have any hypersensitivity or allergy to any drugs? ________________________

Do you have any food intolerances or allergies? ______________________________

Do you have any environmental sensitivity? __________________________________

General

Height: _________ Weight: _______ lbs Weight 1 year ago: _______ lbs

How many ounces of water do you drink daily? __________ oz.

How many cups of coffee? ______ Sodas? ______ Alcoholic beverages? ______

Check any food cravings you have:

☐ Salt ☐ Chocolate ☐ Sweets ☐ Breads ☐ Pastas ☐ Fried Foods

Other cravings: ____

List typical meals:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Dental

Do you have any root canals? ☐ Yes ☐ No If yes, how many? __________

Do you have any amalgam fillings? ☐ Yes ☐ No If yes, how many? _________

Habits

How many hours *per day* do you spend:

Watching TV ________ In Meditation ________ In Prayer ________ Reading ________

How many hours *per week* are social? ________ friends? ________ church? ________

Do you exercise? ☐ Yes ☐ No If yes, how often? __________________________

Do you smoke? ☐ Yes ☐ No

If yes, how long? ___________ How many per day? ___________

Do you use recreational drugs? ☐ Yes ☐ No

If yes, which ones? _____________________

Rate your energy between 1 (Low) and 10 (High): ________

Rate your stress between 1 (Low) and 10 (High): ________

Sleep

How many hours of sleep do you get on average? ________________________________

Do you have difficulty falling asleep? ☐ Yes ☐ No

Do you wake up during the night? ☐ Yes ☐ No If yes, how often? ____________

Do you feel refreshed in the morning? ☐ Yes ☐ No

Digestive Health

How frequently do you move your bowels? ______________________________________

Check any of the following that you experience:

☐ Loose Stools
☐ Diarrhea
☐ Hard Stool
☐ Difficulty Passing
☐ Blood in Stools
☐ Undigested Food in Stools
☐ Mucous in Stools
☐ Gas
☐ Bloating
☐ Heartburn/Reflux
☐ Abdominal Pain

Do you have your gallbladder? ☐ Yes ☐ No

Do you have your appendix? ☐ Yes ☐ No

Female Reproductive

Age of your first menstrual cycle: _______ How long is your cycle?: ________________

Do you get yeast infections? ☐ Yes ☐ No

History of abnormal pap? ☐ Yes ☐ No

Are you menopausal? ☐ Yes ☐ No If yes, age of last menses: ___________

Have you had a hysterectomy? ☐ Yes ☐ No

Check any of the following that you experience:

☐ Heavy flow ☐ Light flow ☐ Clotting ☐ Bleeding between periods

If you experience PMS, which symptoms?

☐ Pain or cramping ☐ Headaches ☐ Bloating

☐ Mood swings ☐ Breast tenderness ☐ Cravings

Do you experience any of the following?

☐ Hot flashes ☐ Low libido ☐ Disrupted sleep

☐ Poor memory ☐ Changes in mood ☐ Pain during intercourse

☐ Vaginal itching ☐ Vaginal Dryness

Are you sexually active? ☐ Yes ☐ No Form of contraception: ______________

Male Reproductive

Please indicate if any of the following applies to you:

☐ Impotence ☐ Sexually Transmitted Disease ☐ Sores on genitals

☐ Discharge ☐ Testicular mass ☐ Testicular pain

☐ Hernia ☐ Infertility/Low sperm count ☐ Prostate Condition

Are you sexually active? ☐ Yes ☐ No Form of contraception: ______________

Please check areas of concern, symptoms or Medical Diagnoses (by a licensed medical practitioner). Write “P” besides the box if you have experienced these in the past.

General
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Change in thirst
- ☐ Cravings
- ☐ Weight gain
- ☐ Weight loss
- ☐ Poor sleep
- ☐ Chills or fever
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes

Skin and Hair
- ☐ Dryness
- ☐ Rash
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Recent moles
- ☐ Hives/allergic reactions
- ☐ Loss of hair
- ☐ Thinning hair
- ☐ Dandruff
- ☐ Other skin problem(s)

Eyes, Ears, Nose & Throat
- ☐ Eye pain
- ☐ Eye strain
- ☐ Blurry vision
- ☐ Impaired vision
- ☐ Cataracts
- ☐ Ear aches
- ☐ Ear infections
- ☐ Ringing in ears
- ☐ Vertigo or dizziness
- ☐ Sinus infections
- ☐ Nasal obstruction
- ☐ Post nasal drip
- ☐ Nosebleeds
- ☐ Loss of smell/taste
- ☐ Tonsillitis
- ☐ Sores in mouth
- ☐ Mercury fillings
- ☐ Jaw pain or clicks
- ☐ Recurrent sore throat
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Facial pain/tics
- ☐ Headaches

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Irregular heartbeat
- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ Fainting
- ☐ Varicose veins
- ☐ Deep leg pain
- ☐ Cold hands or feet
- ☐ Anemia
- ☐ Easy bruising

Respiratory
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Wheezing
- ☐ Coughing blood
- ☐ Phlegm in throat

Muscle, Bone & Joints
- ☐ Neck pain
- ☐ Back pain
- ☐ Arthritis
- ☐ Bursitis
- ☐ Joint pain or stiffness
- ☐ Artificial joint
- ☐ Muscle pain
- ☐ Muscle weakness

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Reflux or heartburn
- ☐ Constant hunger
- ☐ Ulcer
- ☐ Gallstones
- ☐ Constipation
- ☐ Diarrhea
- ☐ Chronic laxative use
- ☐ Rectal burning/pain
- ☐ Hemorrhoids
- ☐ Blood in stool

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Emotional problems
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Dizziness
- ☐ Seizures/Epilepsy
- ☐ Concussion
- ☐ Lack of coordination
- ☐ Extremity numbness
- ☐ Extremity tingling
- ☐ Paralysis

Infections
- ☐ Strep throat
- ☐ Mononucleosis
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV/AIDS

Urinary
- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Incontinence
- ☐ Pain on urination
- ☐ Wake at night to urinate
- ☐ Urinary tract infection
- ☐ Blood in urine
- ☐ Kidney stones

Signature

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: ______________________________________ Date: _______________

I agree that I am here to receive educational to natural approaches to health. This includes dietary choices, lifestyle, herbal remedies, and alternative therapies. I understand I will be receiving suggestions about nutritional products as well as consultation in regards to the above education.

I fully understand that those who counsel me are not medical doctors and are not here for medical diagnoses or treatment procedures.

The services performed here are at all times restricted to consultation on matters intended for the support of the best wellness and balance for the body and do not involve a diagnosis, cure or treatment of a disease.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it.

I understand during my consultation the Naturopathic Doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, as well as other applicable fees. Notice of 48 hours is required for appointment cancellation, otherwise you will be charged an administrative fee of $35.00.

Patient's Full Name: ____

Date of Consent: ______________________

Signature of Patient: ____