



Today's Date: _____

Name: _____

Age: _____ Date of Birth: _____ Gender: M F

Home Phone: _____ Work/Other Phone: _____

May we leave messages relating to your visits? Y N

Address:

If you would like to receive information via email, please provide your email address:

Occupation: _____ Employer: _____

Marital Status: Sgl Mar Div Sep CL Widowed Number of children: _____

Emergency Contact Name: _____

Relation: _____ Phone: _____

Other health care providers you are seeing:

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

Do you have extended medical insurance? Y N

If yes, state the Naturopathic amount: _____

How did you hear about our Clinic?

Personal Health History

What are your main health concerns, in order of importance to you?

1.

2.

3.

4.

How would you describe the general state of your health?

What do you feel your weakest organ system is (example: immune system, digestive system)?

List the five most significant stressful events in your life:

1.

2.

3.

4.

5.

Which of these situations continues to impact your life?

Indicate any serious conditions, illnesses, injuries and hospitalizations with dates:

Do you have any allergies?

Do you get regular screening tests done by another doctor (PAP, blood tests, prostate exams)?

List all current prescription medications:

List past prescription medications and amount of time on each drug:

Approximately how many times have you been treated with antibiotics?

List all current vitamins, herbs and supplements:

Did you receive routine childhood vaccinations?

List other vaccinations received and any adverse reactions:

Do you frequently use any of the following? Please circle.

Laxatives / Diet Pills / Antacids / Sedatives / Birth Control Pill

Indicate your frequency per day, week or month of the following substances:

Alcohol

Caffeine

Tobacco

Recreational drugs

Do you exercise? How often and what type?

Diet

List any food allergies or intolerances:

List any dietary restrictions:

Describe a typical day's diet:

Breakfast

Lunch

Dinner

Snacks

Beverages

Family Health History

	Age if Living	Age at Death	Health Concerns	Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Other				

Environment

What type of building do you live in? Please circle.

House / Apartment / Condo / Other _____

How old is it? _____

Do you have pets?

Are you frequently exposed to tobacco smoke?

Are you exposed to toxins or other hazards (work, home, hobbies)? Please describe.

How would you describe the emotional climate of your home?

Health Goals

List your health goals in order of importance to you:

- 1.
- 2.
- 3.
- 4.

Is there anything else that you feel is important that has not yet been covered?

Thank you for taking the time to complete this form.