

Holistic Healing Arts Centre
Mary-Leah Albano, B.Sc., M.P.H., N.D.
Doctor of Naturopathic Medicine
Reg. # 1940

Name: _____ Date: _____

Age: _____ Date of Birth (dd/ mm/ yy) _____ Sex: M F

Address: _____ Email: _____

City: _____ Postal Code: _____ Telephone # _____

Occupation: _____ Employer: _____

Emergency Contact: _____

Name

Telephone Number

Does your Insurance cover naturopathic medicine? YES _____ NO _____

How did you hear about us? _____

How can we help you? (what is your health problem?) _____

When did your problem start? _____

What seems to make it better? _____

What seems to make it worse? _____

Are there related symptoms? _____

Are there any other health problems that you would like to have treated?

List in order of importance:

1. _____

2. _____

3. _____

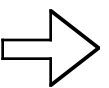
4. _____

What treatments, medicines, drugs are you taking or have taken? When and for how long? How did these methods affect you? _____

What operations (surgery) have you had?	Give date	What effect did it have on you?
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_____	_____	_____
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_____	_____	_____
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Turn Over 

Indicate below, which ailments have affected your relatives. Give ages even if they are/were healthy. Possible ailments include: Alcoholism, Allergies, Arthritis, Asthma, Cancer, Diabetes, Epilepsy, Frequent Colds, Gonorrhea, Gout, Hay Fever, Heart, Hysteria, Insanity, Nervous Breakdown, Paralysis, Pneumonia, Skin Infections, Syphilis, TB, Ulcers, and others.

	AGE IF ALIVE	AGE AT DEATH	AILMENTS
FATHER			
MOTHER			
BROTHERS			
SISTERS			
MATERNAL GRANDFATHER			
MATERNAL GRANDMOTHER			
MATERNAL AUNTS/UNCLES			
PATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
PATERNAL AUNTS/UNCLES			

Have you ever been to a Naturopathic Physician before? YES NO

Do you know what a Naturopathic Physician does? YES NO

(Please Indicate painful areas with an "X".)

