

Holistic Healing Arts
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Doctor of Naturopathic Medicine
Registration #1638



Name _____ Date _____

Date of birth _____ Gender: _____

Address: _____

City: _____ Postal Code: _____

Phone number (circle your preference):

Home: _____ Mobile: _____ Work _____

E-mail Address: _____

If needed, can I e-mail you regarding discussion we had in your visit? Y / N

Emergency contact: Name: _____

Phone: _____ Relation: _____

Does your insurance cover consultations with a Naturopathic Doctor? Y / N

How did you hear about the clinic? _____

Other health care providers you are seeing:

1. _____ _____ _____ (____) _____	2. _____ _____ _____ (____) _____	3. _____ _____ _____ (____) _____
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What are your health concerns, in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

If you are female are you currently pregnant or do you suspect yourself to be pregnant?

Yes No (Please circle one)

Medical history

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

Do you have any allergies (medicines, environmental, etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Please list past prescription medications.

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Marijuana or Hashish _____

Other Recreational drugs—what and how often _____

Please indicate what immunizations you have had

<input type="checkbox"/> DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/> Haemophilus influenza B	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Tetanus booster; when? _____	<input type="checkbox"/> "Flu"	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> Polio	<input type="checkbox"/> Smallpox

Other _____

Please indicate if any caused adverse reactions:

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

Diet

Do you have any food allergies or intolerances? Please list.

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Please indicate which family member
Allergies	
Asthma	
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Depression	
Other Mental Illness	
Drug Abuse/Alcoholism	
Kidney Disease	
Other	

I don't know my family medical history

Environment

Occupation _____

Hobbies _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?

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

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

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

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