

Name	Date of Birth	Appointment Date/Time
Address	City	State, Zip
Email	Home Phone ()	Mobile Phone ()

What are your goals for this visit?

Concern (please rank by priority) Example: Headaches	Onset June 1998	Frequency 4 times/week	Severity mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Medical History	Please indicate if you have /or ever had		List family members who have had these illnesses (siblings, parent, children, grandparent)
	Past	Present	
Heart Disease	<input type="radio"/>	<input type="radio"/>	_____
Hypertension	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____
Lung Disease (asthma etc)	<input type="radio"/>	<input type="radio"/>	_____
Hepatitis	<input type="radio"/>	<input type="radio"/>	_____
Digestive Disorder	<input type="radio"/>	<input type="radio"/>	_____

Seizures	<input type="radio"/>	<input type="radio"/>	_____
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	_____
Other _____	<input type="radio"/>	<input type="radio"/>	_____
Other _____	<input type="radio"/>	<input type="radio"/>	_____
Other _____	<input type="radio"/>	<input type="radio"/>	_____

Comments _____

Allergies
Medication

Reaction/Intolerances

Food

Reaction/Intolerances

Environment

Reaction/Intolerances

FAX To: 851-8657

What vitamins//minerals/supplements are you taking now?

Brand or Other Name	Reason	When started	Dosage per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many times have you taken antibiotics in the last 10 years? _____

How many times have you taken oral steroid medication in the last 10 years? _____

Occupation

What hobbies/interests do you have?

Who do you live with? (include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



What Physical Activity do you participate in?

Would you like to discuss an exercise regimen?

What are the major stressors in your life?

What do you do to relax?

Religious affiliation , past and present

What prior experiences have you had with alternative medicine?



How many servings of fruit do you eat/drink per day?

(one serving = 1 small fruit, 1/2 cup juice, 1/2 cup canned or chopped fruit, 1/2 dried fruit)

How many servings of vegetables do you consume each day?

(one serving = 1/2 cup raw or cooked vegetables, 1 cup fresh, green leafy vegetables, 1/4 cup dried vegetables, or 1 small piece)

Are you currently on a special diet? If so, please describe:

What type of oil or spreads do you add to your food?

What do you drink on a typical day?

How would you describe your relationship with food?

Need more space?

