DATE _____

PATIENT PROFILE

Last Name:_____ First Name: _____

Nickname: _____ Birthdate:_____ Sex: _____

A note to our patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas: Draw or list
1.		
2.		
3.		
4.		
5.		

What goals do you have for your visit at the clinic today? _____

_____

Have you ever consulted a Naturopathic physician, an Acupuncturist, a Nutritionist or a Counselor before? (please circle)

Do you have any questions about our clinic or the care that you've chosen today?_____

_____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any allergies to medications, foods, etc:_____

Explain: _____

Personal Habits:

Please circle any of the following substances that you use regularly: Tobacco Coffee/black tea/cola Alcohol Recreational drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Do you exercise regularly? ❑Yes ❑No What type? _____

How long? _____ How often?_____

Past History:

Hospitalizations: _____

_____

Serious Illnesses and Injuries: _____

_____

Date of last physical/annual exam _____ Date of last blood tests: _____

Personal and Family History:

Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	DATES RESOLVED Past(P)/Current(C)		YES	RELATION	DATES RESOLVED Past(P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History:

Please circle those that apply: Single Married Separated Divorced Widowed Other

Do you have any children? Yes No Please list their age(s) _____