DOCTOR OF NATUROPATHIC MEDICINE

Name: _____ Age: _____ Date of Birth _____/_____/_____

(Last/First/Middle Initial) Year Month Day

Address:_____

Street / Mailing City Postal Code

Home Phone: (____)_____ Work Phone: (____)_____ Cell: (____)_____.

May we leave messages relating to your visits? Yes / No Email address: _____

Emergency Contact Name: Phone Number:

Marital Status: S M D W Sep Number of Children: _____ Referred by: _____

Occupation: _____ Employer: _____

If you are female, are you currently pregnant? Yes / No Carecard Number:_____

MAJOR CONCERNS IN ORDER OF IMPORTANCE TO YOU

Concern	Since	Possible Causes

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

Medication + Dosage	Since	Adverse Effects

WHAT OTHER TREATMENTS AND/OR VITAMINS ARE YOU CURRENTLY FOLLOWING?

Treatments	Vitamins	Since

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

Abscesses	Emphysema	Kidney Disease	Pneumonia	Typhoid Fever
Alcoholism	Endometriosis	Leukemia	Prostatitis	Venereal Warts
Allergies	Epilepsy	Malaria	Psoriasis	Warts
Anemia	Gall Stones	Measles	Rheumatic Fever	Whooping Cough
Arthritis	Goitre	Migraine Headaches	Rubella	Worms
Asthma	Gonorrhea	Miscarriage	Scarlet Fever	Yellow Fever
Cancer	Gout	Mononucleosis	Strep Throat	
Chicken Pox	Hay Fever	Mumps	Sinusitis	
Cold Sores	Heart Disease	Parasites	Stroke	
Depression	Hepatitis	Pelvis Inflammatory Disease	Syphilis	
Diabetes	Herpes	Peritonitis	Tonsillitis	
Eczema	Influenza	Pleurisy	Tuberculosis	

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Operation	When	Concerns

Injury	When	Long Term Effects

Age of first menstruation: _____ Number of pregnancies: _____

What vaccinations have you had? _____

Any adverse effects from taking them? _____

Have you ever taken antibiotics for a prolonged period of time? _____When? _____

For what conditions? _____

Have you lost any weight lately? Yes / No How many pounds?_____

What exercise do you do and how much?_____

HOW MUCH OF THE FOLLOWING ARE YOU USING?

Tobacco:	Tea:	Alcohol:
Coffee:	Recreational Drugs:	

INDICATE BELOW, WHICH IF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR AILMENTS HAVE AFFECTED YOUR RELATIVES?

Alcoholism	Asthma	Diabetes	Gout	Mental Illness	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

ARE YOU CURRENTLY UNDE R THE CARE OF ANOTHER PHYSICIAN(S)?

Physicians	For What Condition?	Treatment

Please advise Staff if this is a Worksafe Claim Visit