DATE _____

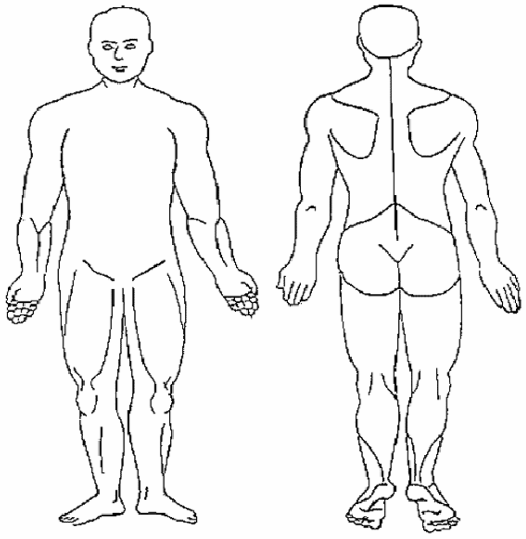
PATIENT PROFILE

Last Name: _____ First Name: _____

Nickname: _____ Birthdate: _____ Sex: _____

A note to our patients: Please complete this *two-sided* questionnaire as thoroughly as possible. This is a confidential record of your medical information and will not be released, except under the guidelines of the Notices of Privacy Practices.

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:
1.		
2.		
3.		
4.		
5.		

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

_____

Have you ever consulted a Naturopathic Doctor or other alternative medicine provider before? _____

_____

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. _____

Do you have any allergies (medications, topicals, foods, etc.) that are severe or life threatening: **YES** **NO**
If yes, please describe: _____

Personal Habits:

Please circle the following substances that you have used more than once in the past month:

Tobacco (Smoke / Chew) **Coffee/ Black tea / Cola**

Alcohol **Recreational drugs**

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

_____

_____

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

How long?_____How often? _____

Past Medical History:

Hospitalizations: _____

_____

Serious Injuries/Chronic Illnesses: _____

_____

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

Personal and Family History:

Please check the "Self" box next to each condition that applies to you and please list closest family members who have each of the following conditions. Please note whether condition applied in the past (P) or is currently applicable (C).

	Self	P/C	Relation	P/C		Self	P/C	Relation	P/C
Alcohol/Drug Addiction					Headaches				
Allergies					Heart Disease				
Anemia					Hepatitis				
Arthritis					High Blood Pressure				
Asthma					Kidney Disease				
Cancer					Mental Illness				
Depression					STDs				
Diabetes					Stroke				
Eczema					Tuberculosis				
Epilepsy					Other:				

Social History:

Please circle those that apply: Single Married Significant other

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