Natural Medicine Consultation Chart

Name:	Date:
Date of Birth:	Sex:
Address:	Town/City:
Province:	Postal Code:
Email:	
Telephone:	May we leave a message related to your visit?

Emergency Contact Information

Name:	Telephone:
Relation:	

How did you hear about our clinic?: _____

Referred by: _____

Other health care providers you are seeing:

1. _____ 2. _____ 3. _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Main Concern:

_____

How long has this condition persisted?: _____

Previous treatments and results: _____

Other health concerns, in order of importance to you:

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

If you are female, are you currently pregnant? Yes No (please circle one)

Family History

	Who?		Who?
Allergies		Depression	
Arthritis		Other mental illness	
Asthma		Drug abuse/alcoholism	
Heart disease		Thyroid condition	
High blood pressure		Kidney Disease	
Cancer		Other	
Diabetes			

[ ] 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?

_____

How many hours of sleep do you get a night?: _____

Do you wake up during the night? Y / N If so, what time: _____

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?

_____

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

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

How is your home heated? _____

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

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

_____

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 dates. _____

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

_____

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

_____

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 _____

Recreational drugs - what and how often _____

Do you get regular screening tests done by another doctor (blood, pap, 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) _____