

DATE \_\_\_\_\_

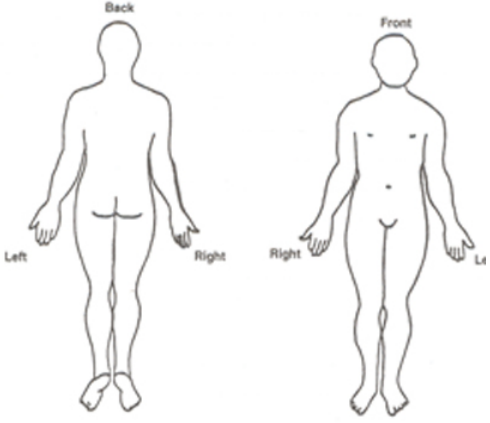
### PATIENT PROFILE

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 physicians 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:
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 severe or life-threatening allergies: \_\_\_\_\_

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 Significant other

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