

HOLISTIC HEALING ARTS

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Reg #1940

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Telephone: _____ If you're unavailable at this number, may we leave a message? Y N

Cell: _____ Email: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Does your insurance cover consultations with a Naturopathic doctor? _____ Remedies Recommended? _____

Name of employer providing insurance coverage _____

How did you hear about us? _____

How can we help you? (what is your health problem?) _____

When did your problem start? _____

What seems to make it better? _____

What seems to make it worse? _____

Are they related symptoms? _____

Are there any other health problems that you would like to have treated? List in order of importance:

1. _____

2. _____

3. _____

What treatments, medicines, drugs are you taking or have taken? WHEN and for HOW LONG? How did these methods affect you? _____

What vitamins or supplements are you taking? _____

What operations (surgeries) have you had?

Give date

What effect did it have on you?

Indicate below, which ailments have affected your relatives. Give ages even if they are/were healthy. Possible ailments include: Alcoholism, Allergies, Arthritis, Asthma, Cancer, Diabetes, Epilepsy, Frequent Colds, Gonorrhea, Gout, Hay Fever, Heart, Hysteria, Insanity, Nervous Breakdown, Paralysis, Pneumonia, Skin Infections, Syphilis, TB, Ulcers, and others.

| | AGE IF ALIVE | AGE OF DEATH | AILMENTS |
|-----------------------|--------------|--------------|----------|
| FATHER | | | |
| MOTHER | | | |
| BROTHERS | | | |
| SISTERS | | | |
| MATERNAL GRANDFATHER | | | |
| MATERNAL GRANDMOTHER | | | |
| MATERNAL AUNTS/UNCLES | | | |
| PATERNAL GRANDFATHER | | | |
| PATERNAL GRANDMOTHER | | | |
| PATERNAL AUNTS/UNCLES | | | |

Have you ever been to a Naturopathic Physician before? YES NO

Do you know what a Naturopathic Physician does? YES NO

(Please indicate painful areas with an "X")

