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")