

Holistic Healing Arts

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Doctor of Naturopathic Medicine

Reg #4015

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")

