

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 clinicians 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?
1.	
2.	
3.	

What goals do you have for your visit at the clinic today? _____

Have you ever consulted a?

Check one: Naturopathic physician Acupuncturist Nutritionist Counselor before

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. _____

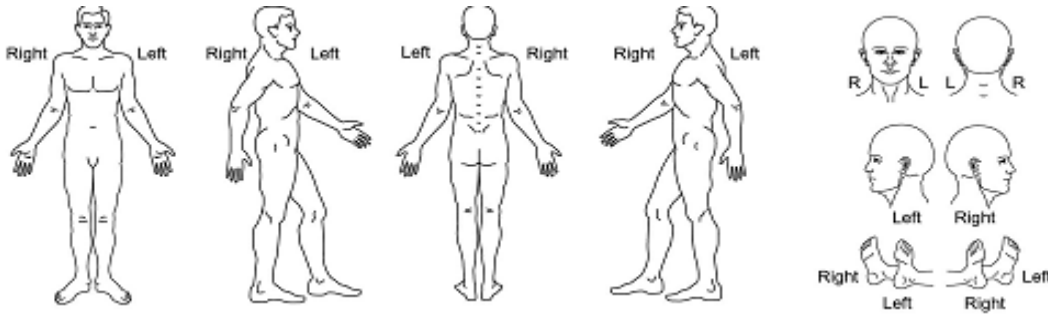
4. _____ 5. _____ 6. _____

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

Are you experiencing any of the following symptoms?(Answer "yes" by circling the appropriate symptom.)

<u>Constitutional symptoms:</u>	fever, weight loss, night sweats, extreme fatigue, sleep disturbance
<u>Eyes:</u>	double vision, sudden loss of vision, eye pain
<u>Ears, nose, mouth and throat:</u>	sore throat, runny nose, ear pain, mouth sores
<u>Cardiovascular:</u>	chest pain, palpitations, swelling, shortness o Breath
<u>Respiratory:</u>	cough, wheezing, shortness of breath
<u>Gastrointestinal:</u>	nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stool.
<u>Genitourinary:</u>	irregular menses, vaginal bleeding after menopause, frequent or painful urination, bloody urine, impotence, change in urination
<u>Skin:</u>	rash, changing mole, wounds,
<u>Neurological:</u>	headache, persistent weakness or numbness on one side of the body, falling, dizziness
<u>Musculoskeletal:</u>	joint pain, muscle weakness, pain, swelling
<u>Psychiatric:</u>	depression, anxiety, suicidal thoughts
<u>Endocrine:</u>	excessive thirst, cold or heat intolerance, breast mass, goiter
<u>Hematologic:</u>	unusual bruising or bleeding, enlarged lymph nodes
<u>Allergic:</u>	seasonal allergies, hives, sinus congestion,
<u>Other:</u>	

If you are currently experiencing pain. Please place an X on areas of your body that are currently painful



Do you have any other items to mention?