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Natural Medicine for the Entire Family™

PROSPECTIVE PATIENT CONSULT FORM

YOUR INFORMATION

NAME_____ TODAY'S DATE _____

AGE_____ DATE OF BIRTH _____MARITAL STATUS_____

ADDRESS_____CITY_____ZIP_____

HOME PHONE _____CELL PHONE_____

EMAIL ADDRESS_____# OF CHILDREN _____

HEIGHT_____WEIGHT_____PREGNANT NOW_____

OCCUPATION_____EMPLOYER_____

WHO REFERRED YOU _____

WHAT BRINGS YOU IN FOR A CONSULT

LIST HEALTH CONCERNS IN ORDER OF IMPORTANCE:

	Rate Severity 1 = Mild 10 = Worst Imaginable	Date started, for how long?	If you had the condition before, when?	What irritates the condition?	Worse at certain times of day?
1.					
2.					
3.					
4.					
5.					

WHAT HAVE YOU DONE FOR THESE CONDITIONS? WAS THERE ANY BENEFIT?

_____

_____

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING ACTIVITIES

WORK _____ SLEEP _____ DAILY ROUTINE _____ SPORTS/EXERCISE _____ OTHER _____

PLEASE LIST TYPES OF DOCTORS YOU HAVE ALREADY SEEN FOR THIS CONDITION

_____

_____

HABITS

- ❑ **Alcohol**: Type_____ Amount_____
- ❑ **Smoking**: Packs daily_____ How long_____ Interested in stopping?_____
- ❑ **Caffeine**: Coffee, soda or tea, cups daily_____ Other _____
- ❑ **Sleep**: Difficulty falling asleep_____ Continuity disturbances_____ Hours of sleep per night _____ Daytime drowsiness_____ Other_____
- ❑ **Exercise routine**:_____ _____ _____ How often_____

MEDICINE / SUPPLEMENTS

PLEASE LIST ALL DRUGS YOU CURRENTLY TAKE OR HAVE TAKEN IN THE PAST 6 MONTHS

NAME _____ DOSAGE _____ FOR WHAT _____
NAME _____ DOSAGE _____ FOR WHAT _____
NAME _____ DOSAGE _____ FOR WHAT _____
NAME _____ DOSAGE _____ FOR WHAT _____

PLEASE LIST ALL NUTRITIONAL SUPPLEMENTS, HERBAL MEDICINE OR VITAMINS YOU PRESENTLY TAKE

NAME _____ FOR WHAT _____
NAME _____ FOR WHAT _____
NAME _____ FOR WHAT _____
NAME _____ FOR WHAT _____
NAME _____ FOR WHAT _____

WHAT DO YOU HOPE TO ACCOMPLISH FROM NATURAL MEDICINE THAT YOU HAVEN'T ALREADY?

HOW LONG DO YOU EXPECT IT TO TAKE TO ACCOMPLISH THAT GOAL?

_____

_____

_____

CONSENT FOR CONSULT

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Doctor's office of any changes in my medical status. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

Signature_____Date_____
(Parent or Guardian, if under 18)