



healthcare for the whole family

Confidential Patient Health Record

Name _____ Age _____

Birth date ___/___/___ Marital status _____
Month / day / year

Address _____ City _____ Postal Code _____

Home Phone: _____

Business Phone: _____

Email Address _____

Profession _____

MD Physician _____

Phone: _____

Person to notify in an emergency _____

Phone: _____

Do you have extended medical? **Y / N**

Is this a referral? **Y / N**

How did you hear about the clinic?

Naturopathic Medicine Informed consent for treatment

I _____ hereby authorize A New Leaf Naturopathic Clinic to perform specific procedures as deemed necessary to facilitate my

diagnosis and treatment. I understand that I am free to withdraw my consent and discontinue my treatment at anytime.

Signature _____

Date: _____

Current Health Condition

What health concerns brought you to the office today?

Please List all medications that you are presently taking

If you take supplements, please list brand, dosage and reason for taking the supplement.

Personal Health Habits

Height: _____ Current Weight: _____ lbs One year ago _____ lbs

Smoker **Y/N** Smoked _____ years Amount/day _____ Year stopped _____

Alcohol Use **Y/N** Type _____ Frequency _____

Recreational Drug Use: **Y/N** Type _____ Frequency _____

Coffee **Y/N** _____ cups/day Tea **Y/N** _____ cups/day Water _____ cups/day

Diet: Is there any foods that you avoid? _____

Is there any foods that you crave? _____

On a scale of 1-10 (*10 being the highest*):

Rate your current stress level _____

Rate you current energy level _____

How Many hours do you sleep/night?_____ Do you wake up rested? **Y / N / Sometimes**

Regular Exercise: **Y / N** Type _____ Duration _____ Frequency _____

Are you currently pregnant? **Y / N / Not Sure (Women only)**

Type of birth control used _____ Last Pap Smear _____

Medical History: *Please check only those that pertain to you personally*

- | | |
|---|---|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Gall bladder /Liver Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gum /teeth problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bladder/urinary problems | <input type="checkbox"/> Heart disorder |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Blood pressure problems / Stroke | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Joint problems |
| <input type="checkbox"/> Frequent colds /flu | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Digestive Disturbances | <input type="checkbox"/> Occupational exposure to toxins |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Psychological Difficulties (suicide/
depression / anxiety / OCD) |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Female Gynecological problems | <input type="checkbox"/> other Please specify _____ |
| <input type="checkbox"/> Mononucleosis | |

Personal Health History

Please list all surgeries that you have had, dates and reasons.

How many times a year do you get a cold or flu? Do you have to miss work because of it?

Please list all allergies (*food and environmental*)

Explain your dental health (*any fillings /root canals*) _____

Any other information that you would like to mention (history/goals etc.)

Thank-you