Dayspring Naturopathic Clinic

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Please complete this form and have it with you for your first visit. It will allow us to use our time together more effective. All information that you disclose is *confidential and not be released* without your permission.

Name: _____ Date: _____
Address: _____ Zip Code: _____
Telephone: (Home) _____ (Work) _____ Birthdate: _____
Emergency Contact (Relationship): _____ Emergency Telephone: _____
Occupation: _____ Email: _____
Name of family physician: _____ Telephone: _____

How did you hear about our clinic? _____

List reason(s) for your visit in order of importance (include date of onset with each concern):
1. _____
2. _____
3. _____
4. _____
5. _____

Are you currently receiving any treatment(s) for these concerns? Have they been effective?
_____
_____

List any current medications (prescription, over-the counter, vitamins, herbs, homeopathics): ___
_____
_____
_____
_____

List any past prescription medications: _____
_____
_____

List any surgeries, hospitalizations, accidents, or serious injuries that you have had: _____
_____
_____
_____

List any known allergies or intolerances: _____

IMMUNIZATIONS

o Measles, mumps, rubella
o Diptheria, pertussis, tetanus
o Polio
o Other _____
o Influenza
o Small pox
o Hepatitis

Have you had any adverse reactions to any immunizations: Explain: _____
_____

PERSONAL HEALTH HISTORY

General state of health:	**Poor**	**Fair**	**Good**	**Excellent**
As adult:	o	o	o	o
As teenager:	o	o	o	o
As child:	o	o	o	o

Is there any condition (physical, mental, or emotional) from which you feel that you have not fully recovered? _____

FAMILY HISTORY

Have any family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions?

o Alcoholism
o Allergies
o Anemia
o Arthritis
o Asthma
o Cancer
o Depression
o Diabetes
o Drug addiction
o Epilepsy
o Headaches
o Heart disease
o Hypertension
o Kidney disease
o Mental illness
o Stroke
o Tuberculosis
o Other? _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

o Abcessess
o Alcoholism
o Allergies
o Anemia
o Arthritis
o Asthma
o Cancer
o Chicken pox
o Cold sores
o Depression
o Diabetes
o Emphysema
o Gonorrhea
o Gout
o Hayfever
o Heart disease
o Hepatitis
o HIV
o Influenza
o Kidney disease
o Leukemia
o Low/high blood pressure
o Lyme disease
o Malaria
o Parasites
o Peritonitis
o Pneumonia
o Pleurisy
o Pelvic inflammatory disease
o Prostatitis
o Strep throat
o Syphilis
o Tonsillitis
o Tuberculosis
o Typhoid
o Venereal warts

o Epilepsy	o Measles	o Whooping cough
o Frequent colds	o Mononucleosis	o Worms
o Gallstones	o Multiple sclerosis	o Yellow fever
o Genital herpes	o Mumps	o Other? _____

LIFESTYLE / ENVIRONMENTAL FACTORS

Do you consume any of the following at least once a week?

o Alcohol	o Coffee	o Recreational drugs
o Antacids	o Fast foods	o Tea
o Artificial sweeteners	o Laxatives	o Tobacco

Do you have any dietary restrictions? Explain. _____
_____

Are you exposed to any chemicals or tobacco smoke at work or at home? Explain. _____
_____

How is your energy level? Rate on a scale of 1 to 10 (1=very low; 10=excellent). _____
_____

How would you describe the emotional climate of your home? _____
_____
_____
_____
_____

Have you ever been physically, sexually, and / or emotionally abused? Explain. _____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stressors? _____
_____
_____
_____
_____

How do you relax (include hobbies and leisure activities)? _____

Is there anything that you feel is important that has not been covered? _____
_____
_____
_____
_____
_____

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT: *By signing this, I hereby authorize the staff of Dayspring Naturopathic Clinic to treat me using naturopathic medicines according to the principles of naturopathic practice. If I desire allopathic medical treatment, I am free to seek such treatment from a physician. I understand Dayspring Naturopathic Clinic will make the best effort to treat but make no guarantee to cure me.*

I certify that the above information is true. I understand that charges will be made and herby agree that I am financially responsible for any such charges.

Signed: _____ Dated: _____