Natural Remedes
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Initial Consultation Questionnaire

Full Name: ____ Date: ______________

Address: ____ Apt. Number: __________

City: __________________________ State: ____________ Zip: ____________________

Home Phone: ______________ Cellular: _________________ Work Phone: ______________

Email Address: ____

Gender: Female Male Marital Status: ______________ Date of Birth: ____________________

Emergency Contact's Name: ____

Phone Number: _______________________ Relationship to Patient: _______________________

Patient's Occupation: ____

How did you hear about us? ____

Please list both prescribed and over the counter medications including dosage:

1. ____
2. ____
3. ____
4. ____

Do you take Vitamins and Minerals? Yes No If so, Which ones?

1. ____
2. ____
3. ____
4. ____

Do you take probiotics? (Such as yogurt or any other oral enzyme that restores bacteria to the body): ____________

____

How do you take the probiotics? (pills, liquid, with food): ___________________________________

Current/Recent Physicians			
Name	Specialty	Phone Number	Last Seen

Females only: What was the date of your last menstrual cycle? ____________ Are you currently pregnant? Y N

In the last year, what conditions have you been treated by a physician for? ____

____

____

Please list any other health problems/hospitalizations you have had: _____________________________________

____

____

List any medical conditions:

1. ____
2. ____
3. ____
4. ____

List any allergies:

1. ____
2. ____
3. ____
4. ____

What will you like to achieve in today's consultation? ____

____

____

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections

Alcohol – how much/ day or week: ____

Tobacco – form and amount/day: ____

Caffeine – form and amount/day: ____

Recreational drugs – what and frequency: ____________________________________

Do you get regular screening tests done by another doctor (pap, blood tests, etc.)? Y / N

Do you have any dietary restrictions? ____

____

Do you cook your own meals? Y / N # of days per week you eat out: _________

# of bowel movements per day: ________ Do you experience gas/bloating on a regular basis: Y / N

How many hours of sleep do you get at night? ____

Do you wake during the night? Y / N If yes, how often? _______________________________________

Describe a typical day's diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Family History:

Indicate if a close relative (parent/ child/ sibling) has had any of the following: Who?

Allergies		Depression	
Arthritis		Other mental illness	
Asthma		Drug/ alcohol abuse	
Heart disease		Thyroid condition	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes		Other	

Do you exercise regularly? Y / N   If yes: what form of exercise, how often, and at what intensity? ____________________

____

____

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

____

____

How stressful is your work, and other aspects of your life? How well do you handle these stresses? ____________________

____

____

Are you regularly exposed to toxins and other hazards (work, home, hobbies, etc.)? Please describe. ____________________

____

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

____

Which consultation would you prefer today? (Please check one)

Initial Consultation
$75 (30 min)

Full Consultation
$150 (1 ½ hr – 2hrs)

* Follow-ups are $50