The Natural Cure

112 N. Church St, Clayton, NC 27520
(919) 422-3585
DrDarar@thenaturalcure.net
Thenaturalcure.net

Client Information

Name: _____ Age: _____ Date: _____

Phone: _____ DOB: _____ Email address: _____

Occupation: _____ Who referred you? _____

When & Where did you receive your last medical care?

_____

For what reason?

_____

Why are you here today? _____

_____

_____

Please list any and all medications you are taking including painkillers, laxatives and vitamins and other supplements:

_____

_____

Please list your general diet for most of your life: (be truthful!)

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Do you eat:

Eggs: _____Often _____Sometimes____ Never

Meat: _____Often _____Sometimes____ Never

Chicken: _____Often _____Sometimes____ Never

Fish: _____Often _____Sometimes____ Never

Milk: _____Often _____Sometimes____ Never

Cheese: _____Often _____Sometimes____ Never

Butter: _____Often _____Sometimes____ Never

Yogurt: _____Often _____Sometimes____ Never

Sugar: _____Often _____Sometimes____ Never

Fruits: _____Often _____Sometimes____ Never

Salads: _____Often _____Sometimes____ Never

Cooked Veg: _____Often _____Sometimes____ Never

Coffee: _____Often _____Sometimes____ Never

Potatoes: _____Often _____Sometimes____ Never

Rice: _____Often _____Sometimes____ Never

Pasta: _____Often _____Sometimes____ Never

Breads: _____Often _____Sometimes____ Never

Salt: _____Often _____Sometimes____ Never

Would you say you eat a lot of junk food? Y N

If you drink coffee, how many cups per day? ____

Do you smoke? Y N Do you crave sweets? Y N Chocolate? Y N

Do you drink alcohol? Y N if yes how many drinks per week? _____

How do you sleep? _____ Energy Level: 1-2-3-4-5-6-7-8-9-10 **(1=lowest, 10 highest)**

Do you have bowel distress such as gas, pain or constipation? **Never Sometimes Always**

Do you eat sushi? (Raw fish) Y N If yes, how often? _____

Do you have pets? Y N

Do you exercise? Y N Types _____ How many times a week? _____

How many glasses of water do you drink a day? _____

Have you had any major emotional traumas that you feel have affected your health? Y N

Family History

Do you have a family history of any of the following, including parents, siblings, children and spouse?

Cancer: Y N Who? _____

Diabetes: Y N Who? _____

Heart Disease: Y N Who? _____

Hepatitis: Y N Who? _____

High Blood Pressure: Y N Who? _____

Stroke: Y N Who? _____

Epilepsy: Y N Who? _____

Mental Illness: Y N Who? _____

Asthma: Y N Who? _____

Kidney Disease: Y N Who? _____

Glaucoma: Y N Who? _____

Tuberculosis: Y N Who? _____

Please Circle Yes or No

Scarlet Fever Y N Diphtheria Y N Rheumatic Fever Y N

Mumps Y N Measles Y N German measles Y N

What hospitalizations or surgeries have you had?

_____

X-rays, CAT scans, MRI have you had?_____ Electrocardiogram Y N
Electroencephalogram Y N

Immunizations:

Polio: Y N Tetanus Shot: Y N Measles/Mumps/Rubella: Y N

Small Pox: Y N

Other _____

Please list any known allergens, food, drugs or other_____

_____

Please list your health concerns as to why you are here and what you'd like help with:

_____
_____
_____
_____
_____
_____