The Natural Cure

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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 Have you ever smoked? 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 many hours of 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 If yes, what type?____________________________________

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

How many glasses (8 ounces) 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?

____

Have you had the following vaccines:

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

Small Pox: Y N Flu: Y N COVID: Y N

Chicken Pox: Y N

Please list any known allergens, food, drugs or other________________________________

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

____

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