

WHITE LOTUS NATUROPATHIC CLINIC

Date: _____

| | | | |
|---------------------------|--------------------------|----------------------|--|
| Name: _____ | Age: _____ | Date of Birth: _____ | |
| Address: _____ | City _____ | Postal Code: _____ | |
| Home Phone: (____) _____ | Work Phone: (____) _____ | | |
| Emergency Contact : _____ | Phone: _____ | | |
| Occupation: _____ | Marital Status | S M D W | |
| Email address: _____ | | | |

Referral Source (please circle any/all which apply)

| | |
|--------------|-------------------------------------|
| Yellow Pages | Other media (TV, Newspaper article) |
| Website | Health Care Practitioner _____ |
| Street Sign | Friend/Family _____ |

Major health concerns/goals of treatment in order of importance

1. _____
- 2.. _____
- 3.. _____
- 4.. _____
- 5.. _____

What medications, treatments or supplements are you currently taking?

| | | |
|-------|--------------|------------------------------|
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |

Which of the following conditions have you had(use N for conditions you have now or P for those you have had in the past)?

| | | | | | | |
|--|---------------------|------------------------|------------------------|------------------|--------------------------|------------------|
| | Anxiety | Mononucleosis | Tuberculosis | Acid reflux | Pain | HIV |
| | Addictions | Diabetes | Asthma | Bloating | Frequent dental problems | Hepatitis |
| | Depression | Goitre/Thyroid disease | Chronic cough | Parasites | Eczema | Other(list here) |
| | ADD/ADHD | Irregular periods | Shortness of breath | Constipation | Acne | |
| | Sleeping Disorders | Fibroids | Dizziness | IBS | Psoriasis | |
| | Sinusitis | Ovarian cysts | Fatigue | Cancer | Other skin eruption | |
| | Allergies | Gall Stones | Fibromyalgia | Cysts | Tremors or tics | |
| | Frequent Infections | High cholesterol | Migraines or Headaches | Poor circulation | Numbness or tingling | |
| | Ear infections | Heart Disease | Poor appetite | Water retention | Epilepsy | |
| | Pneumonia | Kidney Disease | Stomach Ulcers | Arthritis | Anemia | |

ANY OTHER MAJOR CONDITIONS? _____

Are there any of the preceding conditions after which you have never been totally well again or which have been more severe than usual? Which ones? _____

What surgeries/hospitalizations have you had?

| Type of Surgery/Hospitalization reason | Date/Year | Any Complications |
|--|-----------|-------------------|
| | | |
| | | |
| | | |

What major injuries have you had?

| Injury | Date/Year | Long Term Effects |
|--------|-----------|-------------------|
| | | |
| | | |

Has your weight changed recently? How many pounds have you lost or gained? _____
 What exercise do you do and how much? _____

If you are a female: are you currently pregnant? Y N
 Number of pregnancies _____ Number of live births _____
 Are you menopausal? Y N Date of Last menstrual period _____

Please indicate below, which of the following major ailments have affected your relatives?

| Alcoholism Allergies Arthritis | Asthma Cancer Depression | Diabetes Epilepsy Genetic Diseases | High Cholesterol Hay Fever Heart Disease | Mental Illness Paralysis Pneumonia | Skin Disease Syphilis Tuberculosis |
|--------------------------------------|--------------------------------|--|--|--|--|
| RELATIVE | AGE IF ALIVE | AGE AT DEATH | AILMENTS | | |
| Mother: | | | | | |
| Father: | | | | | |
| Brothers: | | | | | |
| Sisters: | | | | | |
| Children: | | | | | |
| Maternal Grandmother | | | | | |
| Maternal Grandfather | | | | | |
| Maternal Aunts/Uncles | | | | | |
| Paternal Grandmother | | | | | |
| Paternal Grandfather | | | | | |
| Paternal Aunts/Uncles | | | | | |

Do you have any dietary restrictions? (vegetarian/vegan, religious, food allergies/intolerances etc.)
