

**NEW CLIENT PROFILE**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Current Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Ok to leave message? Yes No

Work Phone: ( ) \_\_\_\_\_ Ok to leave message? Yes No

Cell Phone: ( ) \_\_\_\_\_ Ok to leave message? Yes No

Email: \_\_\_\_\_ Ok to leave message? Yes No

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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**HEALTH INFORMATION - Confidential**

1) State your current health concerns/symptoms/doctor diagnosis of any health problems:

\_\_\_\_\_ Duration \_\_\_\_\_  
\_\_\_\_\_ Duration \_\_\_\_\_  
\_\_\_\_\_ Duration \_\_\_\_\_

2) Please prioritize your health concerns if there are more than one:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

3) Please list any diseases or health problems that you or your family have a history of:

History of: \_\_\_\_\_ Relative: \_\_\_\_\_ History of : \_\_\_\_\_ Relative: \_\_\_\_\_  
History of: \_\_\_\_\_ Relative: \_\_\_\_\_ History of: \_\_\_\_\_ Relative: \_\_\_\_\_

4) Please list any major illness or surgeries you have experienced:

\_\_\_\_\_

5) Are you currently under any emotional or physical stress? If so, please list:

\_\_\_\_\_

6) Do you smoke? If so, how many per day? \_\_\_\_\_

7) Do you drink alcoholic beverages? If so, how many per day? \_\_\_\_\_

8) Have you been to a Doctor of Naturopathy before? If so, what was the outcome? \_\_\_\_\_

\_\_\_\_\_

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9) Do you exercise, if so, what activity and how often? \_\_\_\_\_  
\_\_\_\_\_

10 Your major goal for the first visit. Please tell me what you would like to accomplish today. \_\_\_\_\_  
\_\_\_\_\_

11) Please list any medications you are taking and indicate what they are for:

<u>Medication Name:</u>	<u>Used For:</u>	<u>Duration of use:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

12) Please list any herbal or vitamin supplements you are currently taking or attach a list.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13) Allergies: Please list all food, environmental, and/or drug allergies: \_\_\_\_\_  
\_\_\_\_\_

14) Women that are pregnant or nursing, please check here. Pregnant\_\_\_\_ Nursing\_\_\_\_