**A: Contact Information**

Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M/F

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City Province Postal Code

Preferred Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Children: \_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can Dr. Ariel Jones contact you via email? Y / N (Please circle)

Would you like to receive our monthly newsletter about clinic specials, medical news and a recipe? Y / N

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about me?

☐ Walk-in ☐ Dr. Ariel’s website ☐ Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Newspaper ☐ Social media ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any healthcare providers you are currently seeing:**

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical/annual exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last blood tests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_

**B: Health history**

Please list your main health concerns in order of importance

|  |  |  |
| --- | --- | --- |
| Concern | When it began? | Severity 1-10 |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

Please list the treatments you have tried for the above mentioned concerns:

Do you have any emotional issues that you would like to address?

Do you have any sexual issues that you would like to address?

Do you have any social issues that you would like to address?

Do you have any family issues that you would like to address?

**Official Medical Diagnoses** (Name, When its was diagnosed, and by whom)

1.

2.

3.

4.

**Review of Systems**

I need you to tell me if you are having issues with any of these systems:

**Head** (eyes, ears, nose, throat):
**Respiratory system** (lungs):
**Digestive system** (stomach, intestines, bowel movements):
**Urinary system** (kidneys, urine):
**Sexual system** (any body parts or sexual health, lobido):
**Nervous system** (nerves, tremors, brain problems, shooting pains):
**Cardiovascular** (heart, veins):
**Skin**:
**Endocrine system** (sweating, body odor, fatigue, mood):
**Musculoskeletal** (Muscles, body, aches pains):
**General Markers of Health:**
Sleep (how many hours do you get each night, difficulty falling asleep, waking in the night):
Energy (level, duration throughout the day):
Appetite-
Mood-
Menses-

Length of cycle:

How heavy is the flow:

How many days of flow:

PMS:

Prostate Health:

Stress-what are your biggest stressors in life, how intense is your stress (1-10):

**Allergies** (drugs, herbs, foods, environmental):

**Smoking**- (Cigarettes, marijuana, other + How often/many):

**Hospitalizations**:

**Surgeries**:

**Any and All Medication**:

How many times have you taken anti-biotics?

Did you do a round of probiotics?

**Family history** (cancer, heart attack, diabetes, anxiety disorder etc. for your parents and grandparents:

On a scale from 0-10, how interested are you in changing your health status:

**Credit Card Information**

* To begin the assessment process
* Once we have received all your medical information we will contact you to set up a Skype appointment.

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code/Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I look forward to meeting you,

Dr Ariel Jones, ND