

CENTER FOR TRADITIONAL MEDICINE, P.C.
PATIENT PROFILE

Today's Date: _____

NAME _____ AGE _____ BIRTHDAY _____ SEX _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

(home) _____ (work) _____ (cell) _____

S.S.# _____ E-MAIL _____

FOR MINORS, PLEASE NOTE PARENT'S NAME, BIRTHDAY AND SS#:

OCCUPATION _____ FULL OR PART

TIME _____ RETIRED _____

EMPLOYER _____

LIVE WITH: Partner/ Spouse _____ Parents _____ Relatives _____ Friends _____ Alone _____

EMERGENCY CONTACT:

RELATIONSHIP _____

ADDRESS: _____ PHONE# _____

HOW DID YOU HEAR ABOUT THE CENTER?

A NOTE TO OUR PATIENTS: Preventative Medicine and holistic health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. We are asking you to provide us with part of this picture by carefully and thoroughly completing this health history form. Print all information and mark any questions you do not understand.

You must understand that as naturopathic physicians, we offer an approach to your overall care which may differ from other methods of diagnosis and treatment such as those offered by medical doctors, osteopathic physicians, chiropractors, etc. Our commitment is to provide you appropriate naturopathic care and, to the extent possible, work with other health care providers equally concerned with your well-being. We are NOT medical doctors; we are NOT osteopathic physicians or chiropractors, and will never attempt to take their place in your overall health management.

DO YOU EXERCISE? _____ WHAT FORMS? _____ HOW OFTEN? _____

WHEN AND WHERE DID YOU LAST RECEIVE MEDICAL OR HEALTH CARE?

FOR WHAT REASON?

IN YOUR OPINION, WHAT ARE YOUR MOST IMPORTANT HEALTH PROBLEMS?

1) _____ 2) _____

3) _____ 4) _____

PLEASE COMPLETE BOTH SIDES OF THE FOLLOWING HISTORY FORM AS THOROUGHLY AS POSSIBLE.