Path to Health

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Patient Information Form

Welcome to Path to Health, Holistic Nutritionists. Please be complete and accurate. Your answers to the following questions are the first step in determining your immediate and long-term healthcare needs and concerns. Please elaborate on any questions or add any comments you may have… The more we know about your needs and concerns, the better we can serve you. Be assured that your information is held in the utmost of confidentiality. Thank you!

Personal Information

First Name _____ Last Name _____
Street Address _____ City _____ State ____
Zip _____
Home Phone _____ Cell Phone _____
Email _____ Referred by _____
DOB _____ Sex _____
Marital Status: S M W D Number of Children _____
Occupation _____
Referral Source: _____

Health Information

What is your main health concern? _____
How long have you been experiencing this discomfort?_____Are you:_____Worse_____Better_____ No change_____ Do you have any allergies? _____No Yes_____ Medications?

_____

Foods:_____
Other:_____
Do you have or have had any of the following: (please circle) Stomach Disorder Stomach Stapled Heart disease Hernia High blood pressure Cancer High cholesterol/triglycerides Heartburn Diabetes Thyroid disorder Hepatitis Aids Tuberculosis Herpes Venereal Diseases Herpes
Other_____
What other health or medical challenges/diagnosis do you have:_____

_____

Do you still have the following organs/glands? (Circle if removed)

Gallbladder Uterus Ovaries appendix thyroid tonsils Any other body part removed: _____

Have you had any surgeries or serious illness: _____

Have you had any of the following diseases: (circle all that apply)

Anemia Rheumatic Fever Epilepsy Influenza Mental Disorder Mumps Pleurisy Measles Appendicitis Pneumonia Whooping Cough Polio Chicken Pox

Have you been under the care of a medical doctor? If so whom and for what condition?

_____

_____

On a scale from 1-10 how motivated are you to reach your bodies optimal health potential through nutrition? (Please circle)

Not very 1 2 3 4 5 6 7 8 9 10 **Very**

Family History
Please indicate if there have Diabetes, Kidney, Cancer, Thyroid or other health problems:

Father_____
Mother_____
Siblings_____

I have reviewed the information indicated on this questionnaire and its accurate to the best of my knowledge. I understand that this information will be used to determine appropriate and healthful support. If there is a change in my medical status, I will inform my treating physician.

Signature_____**Date**_____

In case of emergency, whom should we notify:

_____

Relationship_____ **Phone number**_____
Address_____