Health Wanted LLC

Amy L. Graham B.M., M.A.E., B.C.N.D. *Board Certified Traditional Naturopathic Doctor*
at Common Point (517) 438 0750 247 South Main St, Adrian, MI 49221

NEW CLIENT INFORMATION (Please print clearly)

Today's Date ____________

Name: ______________________ Birth Date: ____________ Sex: _____

Address: ______________________ City: ____________ State: _____

Phone (H): ____________ Phone (C): ____________ Email: ____________

Marital Status: ____________ Number of Children: ____

Occupation: ______________________ Hours Worked per Week: _____

Emergency Contact: ______________________ Phone: ____________

Stress Levels *(please circle the number that best corresponds to your level of stress. 1 = low, 5 = high)*

General Stress	Job-Related Stress
1 2 3 4 5	1 2 3 4 5

Current Medications: *(please list additional medications on the reverse side of this page)*

Name	For what?	Duration Dates

Current herbs, vitamins, minerals or other supplements *(please list additional supplements on the reverse side)*

____

____

Your major complaint (*how would you like to improve your health?*): ______________________

Other health information: ______________________

____

____

Level of exercise: (type, duration, frequency) ______________________

Please check applicable conditions:

____	No/low energy	____	Heart problems	____	Allergies
____	Insomnia	____	Diarrhea	____	High blood pressure
____	Cannot relax/anxiety	____	Constipation	____	Low blood pressure
____	Headaches	____	High/low blood sugar	____	Frequently sick
____	Migraines	____	Hiatal hernia	____	Depression or mood disorder(s)
____	Digestive problems	____	Backaches	____	Asthma
____	Chronic indigestion	____	Swollen/painful joints	____	Pregnant
____	Heartburn	____	Muscle problems	____	Female concerns
____	Gas/bloating	____	Cold hands/feet	____	Male concerns
____	High/low appetite	____	Complexion concerns	____	Sexual dysfunction

Information from your physician regarding these conditions (*please also list any conditions not listed above*):

____

____

Surgeries: ____

____

Explain any dietary changes you've made in the last 4 months: ______________________________

____

Your typical breakfast: ____

____

Please indicate if you do now, or if you have in the past:

____	Smoke	How much/often? ______________________
____	Drink alcohol	How much/often? ______________________
____	Drink soda/pop	How much/often? ______________________
____	Drink coffee	How much/often? ______________________
____	Have food cravings	What/when? ______________________

IMPORTANT: I _________________________________ understand that the suggested nutritional and dietary information is not intended as the diagnosis, cure, mitigation, treatment or prevention of disease or the primary therapy for any disease or symptom. It is intended to assist me in changing my habits and helping me to establish a new lifestyle in order to build good health naturally. I understand that these suggestions are provided to grade the quality of foods in my diet in order to supply good nutrition for supporting physiological and biochemical processes of the human body. ***I understand that it is my personal decision whether or not to follow the natural health suggestions offered.***

I understand that the Traditional Naturopathic Doctor I am visiting is not a medical doctor and does not treat or diagnose medical conditions. If I need medical counseling for a medical condition, I will seek a qualified medical professional.

Signature: ____ Date:____________