

Please Print

Date: _____ Home Phone: _____ Work Phone: _____

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____

Occupation: _____ Referred By: _____

AGE: _____ SEX: MALE _____ FEMALE _____

WEIGHT: _____ HEIGHT: _____

BLOOD PRESSURE: _____ pH: _____

What is your major complaint? _____

Please list current symptoms, when they began, and are they diminishing, escalating, or unchanging: _____

What changes have you noticed with your body? _____

List ALL medications you are currently taking including over the counter drugs & supplements: _____

List any medications you have taken in the past that you are no longer currently taking: _____

Do you have any medical or food allergies that you are aware of; please list: _____

Any organs or parts removed, and if so, which? _____

Have you ever had any serious injuries or accidents? Please list. : _____

Have you ever had or been diagnosed as having problems with any of the following:

- | | | | | | |
|--|------------------------------------|---------------------------------------|--|---------------------------------|------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Weight | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menopause | <input type="checkbox"/> Lungs | <input type="checkbox"/> Throat |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Ovaries | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hiatus Hernia | <input type="checkbox"/> Coffee | <input type="checkbox"/> Thyroid | <input type="checkbox"/> High/Low Blood Pressure | | |

Heart Burn Breast Skin/Acne Headaches Burping/Gas/Bloating

Spleen Gallbladder PMS Edema Pancreas

Fibromyalgia Numbness in hands/feet Weight Tumors

OTHER – please specify: _____..

If there are other aspects of your medical history of which we should be aware, please indicate:

LIFESTYLE QUESTIONNAIRE:

Describe your normal meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Please list your normal day's fluid intake:

Water _____ Alcohol _____ Coffee/Tea _____ Soda _____

Juice _____ Other _____ What type of water do you drink? _____

Do you smoke tobacco? _____ How often? _____

Do you use recreational drugs of any kind? _____ How often? _____

Do you exercise regularly? _____ What type and how often? _____

Do you have regular bowel movements? _____ How often? _____ Do you wake up at night to urinate? _____

Do you chemically process your hair with dyes or perms? _____

Do you use personal hygiene products that contain chemicals? _____

Have you ever been diagnosed with depression? _____

EMOTIONAL STATE:

Do you feel depressed? _____ For how long? _____ Do you feel anger or resentment? _____

If so, how do you react to these feelings? _____

Are you irritable? _____ Do you feel any anxiety or nervousness? _____

Do you have any specific fears? _____

Do you feel stressed? _____ In what way? _____

Have you been under any extreme pressure? _____

Has there been any significant changes in your life? (divorce, death of a loved one, or loss of employment for example).

Have you had any traumatic experiences in your life? _____

Do you feel fatigued? _____ Are your sleep habits normal or abnormal? _____ Explain _____

How do you feel about yourself? _____ Do you believe in yourself? _____

Are you a spiritual person? (in whatever way you define spirituality) _____

Do you believe in a higher self? _____

I recognize that Laura Dyke, ND, CNHP *is not an* allopathic or medical doctor, nor does she represent herself as one. She *does not* treat, diagnose or prescribe any drugs. She *does not* do surgery, take X-rays or handle pregnant patients. Laura Dyke *is a Doctor of Naturopathy, Traditional Naturopath, and Certified Natural Health Professional* that researches and teaches about the benefits of natural therapies, vitamins, minerals and supplements.

I believe it is my constitutional right to seek Laura Dyke, ND, CNHP's counsel and wisdom concerning my well-being and the maintenance of my health.

I do hereby give Laura Dyke, ND, CNHP permission to counsel me concerning my health and well-being, and to recommend any supplements that she deems necessary and to recommend a proper diet. I further understand that many of these natural remedies are still being researched and absolute results cannot be guaranteed. If I choose to follow Laura Dyke, ND, CNHP's advice, I do so at my own free will, and I am under no obligation to take or purchase anything.

Signature: _____ Date: _____