Client Information

Personal and Historical Data

Complete Each Answer. Put "N/A" for Not Applicable; fill Boxes That Apply.
If Not Completing This Online, Please Use INK And PRINT Answers.

CONTACT INFORMATION, PERSONAL AND WORK DATA

CLIENT'S NAME: (First, Middle, Last Name)	**DATE COMPLETED FORM:**
	EMAIL:
HOME ADDRESS: (UPS will not deliver to P.O. Box)	MAILING ADDRESS (If Different from Home Address)
CITY: COUNTRY:	CITY: COUNTRY:
STATE: ZIP CODE:	STATE: ZIP CODE:
HOME PHONE: ☐ DAY ☐ NIGHT	REFERRED BY:
WORK PHONE: ☐ DAY ☐ NIGHT	RELATIONSHIP TO REFERRAL:
CELL PHONE:	SEX: ☐ M ☐ F AGE: DATE OF BIRTH:
FAX NUMBER:	MARITAL STATUS: ☐ S ☐ M ☐ S ☐ D ☐ W
OCCUPATION:	SPOUSE'S NAME:
Can you receive phone calls at work? ☐ Yes ☐ No	Work Hours: ☐ A.M. ☐ P.M.
If Yes, Best times to Call You, If Necessary? ☐ AM ☐ PM	If you work nights/sleep days, best day times to call?
HEIGHT: Ft. Inches WEIGHT:	Work Exposures: ☐ Chemicals ☐ Metals ☐ Glass ☐ Fumes
SITTING BLOOD PRESSURE: / Without Medicine	WRIST MEASUREMENT (Writing Hand): Inches
EXERCISE: TYPE & FREQUENCY	

FOOD OR ENVIRONMENTAL ALLERGIES (Other Allergies? Complete the "Diet Therapy Patient Intake Form")

FOOD: ☐ Corn ☐ Soy ☐ Gluten ☐ Wheat ☐ Eggs ☐ Shellfish ☐ Dairy **Lactose Intolerant:** ☐ Yes ☐ No ☐ **DTPIF**	
ENVIRONMENTAL: Affects ☐ Sinuses ☐ Lungs ☐ Chest	☐ Chemical Sensitivity ☐ Hay Fever: ☐ Asthma:
Type of Plant(s):	WORSE In: ☐ Spring ☐ Summer ☐ Fall ☐ Winter

THERAPEUTIC SUPPLEMENT FINANCIAL PLAN

PLEASE SELECT THE BOX BELOW FOR THE THERAPEUTIC SUPPLEMENT FINANCIAL PLAN THAT APPLIES TO YOU:
Note: If after reading the article "Therapeutic Supplement Plan – Rabbit-Squirrel-Turtle," you are still unsure as to which to choose, call Dr. Smith immediately at (940) 761-4045 for help and to prevent delays. Designing your therapeutic supplement program is dependent upon your selection as indicated on this form.

☐ RABBIT ☐ SQUIRREL ☐ TURTLE ☐ HORSE (Time Sensitive and Most Severe Health Challenges Require Horse)	**Tweaking My Plan:** (Select one) ☐ $5 or less ☐ $10 or less ☐ Other_____ OR ☐ N/A (i.e., stay at the plan limit)

Client Information

Personal and Historical Data

Complete Each Answer. Put "N/A" for Not Applicable; ☒ Boxes That Apply.
If Not Completing This Online, Please Use INK And PRINT Answers.

BIRTH HISTORY (Answer all known questions. Adult Client? Take time to ask living parents, grandmother or aunt if not known.)

MOTHER'S NAME (M):	FATHER'S NAME (F):
MOTHER'S OCCUPATION:	FATHER'S OCCUPATION:
DAY PHONE:	DAY PHONE:
MARITAL STATUS OF PARENTS: ☐ S ☐ M ☐ D ☐ W	**LIVES WITH:** ☐ M ☐ F **AGE ENTERED SCHOOL**:
HOSPITAL BIRTH: ☐ Yes ☐ No	**HOME BIRTH:** ☐ Yes ☐ No **MIDWIFE?** ☐ Yes ☐ No
DELIVERY: ☐ C-SECTION DRUGS USED: ☐ Yes ☐ No	**BREASTFED UNTIL AGE:** **GOAT'S MILK?** ☐ Yes ☐ No
WERE FORCEPTS USED IN DELIVERY: ☐ Yes ☐ No	**SOLID FOOD STARTED AT AGE:**
FORMULAS USED? ☐ Yes ☐ No If Yes, list brands, if known:	
FORMULA REACTIONS: ☐ Colic ☐ Excess Spitting Up ☐ Vomiting ☐ Gas ☐ Smelly Stools ☐ Diarrhea Other:	
LIST SIBLINGS IF CLIENT IS CHILD OR YOUR CHILDREN IF ADULT: [Give Name, Sex (Male/Female) and Birthdate]	

NUTRITIONAL SUPPLEMENTS (Vitamins, Minerals, Herbs, Homeopathics, Food Supplements)

List Only Those Supplements Taken On A Regular Basis. Need More Space? Complete the "Drug & Supplement List" Form.

BRAND NAME	TYPE OF SUPPLEMENT (Ex: Vitamins OR Minerals OR Vitamins with Herbs OR Minerals with Herbs)	DOSAGE Total Amount In A Day	TAKEN DAILY OR AS NEEDED	DATE STARTED Approx.Date is OK	PURCHASED FROM
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Client Information

Personal and Historical Data

Complete Each Answer. Put "N/A" for Not Applicable; ☐ Boxes That Apply.
If Not Completing This Online, Please Use INK And PRINT Answers.

MEDICAL (ALLOPATHIC) PROFESSIONALS

PHYSICIAN (PRIMARY) Give Complete Information As Nutritional Progress Reports May Be Sent.

NAME OF PHYSICIAN:	NUMBER OF YEARS SEEN BY PHYSICIAN:
ADDRESS:	PHYSICIAN'S SPECIALTY:
CITY:	OFFICE PHONE:
STATE: ZIP CODE:	EMERGENCY PHONE:
DIAGNOSIS:	

PHYSICIAN (OTHER) Give Complete Information As Nutritional Progress Reports May Be Sent.

NAME OF PHYSICIAN:	NUMBER OF YEARS SEEN BY PHYSICIAN:
ADDRESS:	PHYSICIAN'S SPECIALTY:
CITY:	OFFICE PHONE:
STATE: ZIP CODE:	EMERGENCY PHONE:
DIAGNOSIS:	

PHYSICIAN (OTHER) Give Complete Information As Nutritional Progress Reports May Be Sent.

NAME OF PHYSICIAN:	NUMBER OF YEARS SEEN BY PHYSICIAN:
ADDRESS:	PHYSICIAN'S SPECIALTY:
CITY:	OFFICE PHONE:
STATE: ZIP CODE:	EMERGENCY PHONE:
DIAGNOSIS:	

PHYSICIAN (OTHER) Give Complete Information As Nutritional Progress Reports May Be Sent.

NAME OF PHYSICIAN:	NUMBER OF YEARS SEEN BY PHYSICIAN:
ADDRESS:	PHYSICIAN'S SPECIALTY:
CITY:	OFFICE PHONE:
STATE: ZIP CODE:	EMERGENCY PHONE:
DIAGNOSIS:	

Client Information

Personal and Historical Data

Complete Each Answer. Put "N/A" for Not Applicable; Boxes That Apply.
If Not Completing This Online, Please Use INK And PRINT Answers.

DRUGS (PRESCRIBED)

List Only Those Drugs Taken On A Regular Basis. Need More Space? Complete the "Drug & Supplement List" Form.

DRUG NAME	PURPOSE FOR TAKING	STRENGTH Ex: .5 mg.	DOSAGE 1 X 3 D (means one pill three times daily)	DATE STARTED Approximate Date is OK	PHYSICIAN WHO PRESCRIBED
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

DRUGS (Over-The-Counter Or By Mail)

List Only Those Drugs Taken On A Regular Basis. Need More Space? Complete the "Drug & Supplement List" Form.

DRUG NAME	PURPOSE FOR TAKING	STRENGTH Example .5 mg.	DOSAGE 1 X 3 D (means one pill three times daily)	DATE STARTED Approximate Date is OK	PHYSICIAN WHO PRESCRIBED, IF APPLICABLE
1.					
2.					
3.					
4.					
5					

Client Information

Personal and Historical Data

Complete Each Answer. Put "N/A" for Not Applicable; ☒ Boxes That Apply.
If Not Completing This Online, Please Use INK And PRINT Answers.

SURGERIES (Organs/Glands Removed Surgically or Other Types of Surgery)

TONSILS: ☐ YES ☐ NO YEAR:	**OVARIES:** ☐ NO ☐ LEFT ☐ RIGHT YEAR
GALLBLADDER: ☐ YES ☐ NO YEAR:	**UTERUS:** ☐ NO ☐ LEFT ☐ RIGHT YEAR
APPENDIX: ☐ YES ☐ NO YEAR:	**OTHER:** YEAR
HIP REPLACEMENT: ☐ NO ☐ LT ☐ RT YEAR	**KNEE REPLACEMENT:** ☐ NO ☐ LT ☐ RT YEAR
BY PASS SURGERY: 1st / YEAR	2nd / YEAR 3rd /YEAR

CURRENT SYMPTOMS (List Symptoms That Bother You The Most, In Order Of Priority)

SCORE: 10= Extremely Severe & Daily; 7,8,9 = Severe & Frequent; 4,5,6 = Moderate; 1, 2, 3 = Mild Intensity & Frequency.

SYMPTOM	AREA OF BODY	SCORE See Above	DATE OF ONSET or INJURY First notice symptom or injury date.	MEDICALLY DIAGNOSED DISEASE? (List Type of Disease, ex: Diabetes)	INJURY? TYPE (Auto, Sports, Horseback, etc.)	PHYSICIAN WHO DIAGNOSED OR TREATED INJURY (First Initial/ Last Name)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

Client Information

Personal and Historical Data

Complete Each Answer. Put "N/A" for Not Applicable; ☒ Boxes That Apply.
If Not Completing This Online, Please Use INK And PRINT Answers.

OTHER HEALTH CARE PROFESSIONALS

CHIROPRACTOR (Give complete information as Nutritional Progress Reports May Be Sent.)

NAME:	NUMBER OF YEARS SEEN:
ADDRESS:	DATE OF LAST ADJUSTMENT:
CITY:	OFFICE PHONE:
STATE: ZIP CODE:	EMERGENCY PHONE:
DIAGNOSIS:	

OTHER PROFESSIONAL (Naturopathic Doctor, Massage or Physical Therapist, Acupuncturist, etc.)

NAME:	NUMBER OF YEARS SEEN:
ADDRESS:	DEGREES: ☐ N.D. ☐ R.M.T. ☐ P.T. ☐ Acupuncturist:
CITY:	OFFICE PHONE:
STATE: ZIP CODE:	EMERGENCY PHONE:
DIAGNOSIS:	

OTHER PROFESSIONAL (Naturopathic Doctor, Massage or Physical Therapist, Acupuncturist, etc.)

NAME:	NUMBER OF YEARS SEEN:
ADDRESS:	DEGREES: ☐ N.D. ☐ R.M.T. ☐ P.T. ☐ Acupuncturist:
CITY:	OFFICE PHONE:
STATE: ZIP CODE:	EMERGENCY PHONE:
DIAGNOSIS:	

PREVIOUS NUTRITIONIST or DIETITIAN

NAME:	NUMBER OF YEARS SEEN:
ADDRESS:	DEGREES: ☐ Ph.D. ☐ C.C.N. ☐ C.N. ☐ R.D. ☐ B.S.
CITY:	OFFICE PHONE:
STATE: ZIP CODE:	EMERGENCY PHONE:
If history is needed, do we have your permission to contact this professional? (You will be notified in advance.) ☐ Yes ☐ No	
SERVICES: ☐ Diet ☐ Menus ☐ Dietary Consultations ☐ Supplements **Satisfaction Level:** ☐ **High** ☐ **Medium** ☐ **Low**	

ATTACHMENTS: Put a check mark in box to the right if you have attached information regarding….								**No Attachments**	
Health History		**Current Symptoms**		**Drug Therapy**		**Supplements**		**Other**	