vital health
NATUROPATHIC CLINIC

#136 – 2755 Broadmoor Blvd.
Sherwood Park, AB T8H 2W7
Phone: (780) 449-4047
Fax: (780) 449-0454

Date: _____

Name: _____, _____ Gender: M F
(Last Name) (First Name)

Home Phone: (_____) _____ Alternate Phone: (_____) _____

May we leave messages related to your appointments? Y N Is so, which number: HOME ALTERNATE

Age: _____ Birthdate: _____(Day, Month, Year)

Address: _____(Street)

_____(City/Province)

_____ (Postal Code)

Email Address: _____

Occupation: _____ Spouse's Occupation: _____

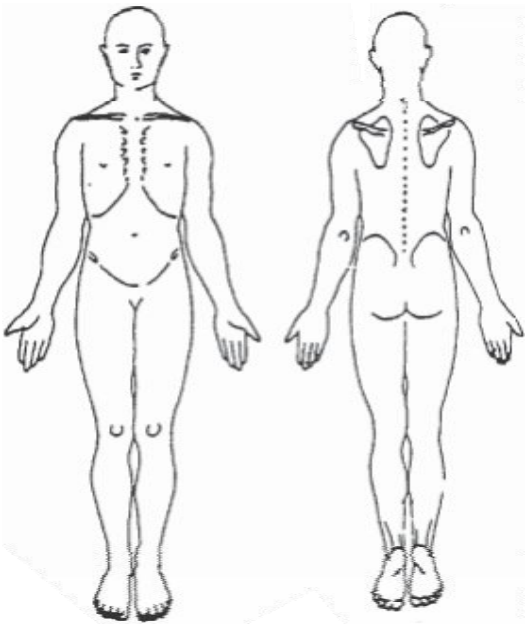
Living Situation: alone / with spouse / with partner / with family / with friend(s)

Other Health Professionals you visit: _____

_____

How did you hear about our clinic: _____

Please circle any areas affecting you.



Briefly outline the reason for your visit today:

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BODY SYSTEM	EXPLAIN ANY DIFFICULTIES YOU MAY EXPERIENCE
Head	
Neck	
Face	
Eyes/Ears	
Nose	
Mouth	
Throat	
Stomach	
Abdomen / Intestines	
Colon / Rectum	
Bowel Movements	
Liver / Gallbladder	
Kidneys	
Urination	
Chest	
Breasts	
Lungs	
Heart	
Circulation	
Blood	
Back	
Hands / Arms	
Feet / Legs	
Joints	
Skin	
Glands / Hormones	
Male / Female Organs	
Sexual Function	
Sleep	
Energy Level	
Mental Function	
Nervous Function	
Emotions	
Weight	

(OVER)

HAVE YOU EVER HAD:	YES If applicable	HAVE YOU EVER HAD:	YES If applicable
Alcohol Problems		Heart Problems	
Anemia		High Blood Pressure	
Arthritis/Gout		Hypoglycemia	
Back Problems		Kidney Troubles/Nephritis	
Broken Bones		Immune Diseases (HIV/AIDS)	
Blood Disorders		Liver, Cirrhosis, Hepatitis	
Cancer		Lung Diseases (TB, Pneumonia)	
Concussion/Head Injury		Mental Problems	
Diabetes		Migraine Headaches	
Eczema/Psoriasis/Hives		Multiple Sclerosis	
Epilepsy		Nervous Problems	
Frequent Colds		Polio/Meningitis	
Frequent Infections		Rheumatic Fever	
Food/Chemical/Drug Poisoning		Sexually Transmitted Diseases	
Gallbladder Troubles/Stones		Stroke	
Glandular or Hormonal Problems		Ulcers, Diarrhea, Colitis	

LIST ANY HOSPITALIZATIONS/SURGERIES
DATE/REASON:
DATE/REASON:
DATE/REASON:

LIST ANY ALLERGIES

LIST MEDICATIONS/SUPPLEMENTS

DAILY HABITS	YES/NO	DAILY HABITS	YES/NO
Physical Exercise: Hours/week _____		Fresh Air & Relaxation	
Smoking: Cigarettes/day_____		Coffee/Tea: cups/day_____	
Alcohol: Drinks/day _____		Soft Drinks: glasses/day _____	
Drugs:		OTHER	