The Olive Leaf

NUTRITION HEALTH FORM & DATABASE

Name		Age	Birth Date	Sex	Date
Address		City		State	Zip
Telephone (Home)	Telephone (Work)	E-Mail			
Employer		Occupation			
Address		City		State	Zip
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Other _____		Do you have any children? □ No □ Yes How Many? _____			
How did you hear about us? □ Living Social □ Health Prof □ Google □ Locly □ Friend □ Other ___		Blood Type: Ethnic Background:			
Rate your overall level of health: □ Excellent □ Very Good □ Good □ Fair □ Poor □ Other: _____					

Chief Complaint:

List your most important health care problems/concerns in order of importance:
1.
2.

History of your present illness (HPI):

Please answer these questions if they apply to your problem.

When did it begin?

Where is the location?

How long has does it last?

What makes it feel better?

What makes it worse?

Any other related symptoms (i.e. fever, diarrhea, pain)?

***Please leave the section below on this page unanswered. Your physician will review these questions with you.*

Quality:

Severity:

Timing:

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Past Medical History:

Please check if you currently have or have had any.

- — Heart Disease (Heart Attack, Bypass, Stent)
- — Diabetes
- — Cancer
- — Thyroid
- — High Cholesterol
- — Gastro Intestinal
- — Mental Health Issues
- — Other

Social History:

Do you exercise? If so, how often?

Mark any of the following foods, drugs, or medications that you routinely use:

	Coffee/Tea		Fast Food		Cigarettes/Tobacco
	Alcohol/Drugs		Soda, including Diet		Olive Oil
	Beef/Pork/ Lamb		Cookies/Cakes/Pastries		White Flour Products
	Chicken		Whole Grains		Fried Foods
	Fresh Vegetables		Dairy Products		Packaged Snack Foods
	Fresh Fruit		Raw Seeds/ Nuts		Beans/ Lentils/ Peas

Are there any foods that make you feel bad or aggravate your symptoms?

List all prescription medications and supplements you are currently taking:

1.	4.
2.	5.
3.	6.

List all allergies/sensitivities to medications or environmental substances:

1.	3.
2.	4.

Family History:

Please check if your parents or siblings have had any of the following:

- — Heart Disease (Heart Attack, Bypass, Stent)
- — Diabetes
- — Cancer
- — Thyroid
- — High Cholesterol
- — Gastro Intestinal
- — Mental Health Issues
- — Osteoporosis
- — Other

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Naturopathic medicine is based on the belief that the human body has an innate healing ability. Naturopathic doctors (NDs) teach their patients to use diet, exercise, lifestyle changes and cutting edge natural therapies to enhance their bodies' ability to ward off and combat disease. NDs view the patient as a complex, interrelated system (a whole person).

We advise you to maintain your relationship with your primary care physician or specialist for ongoing medical management of any medical problems, refills of prescription medications, and for the treatment of any acute illness or injury.

Patient Signature_____Date_____

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Privacy Practices (HIPAA) Form

Record Retention

Records will be maintained in a confidential manner and will be secured in a locked office when not in use by the practitioner.

Clients Rights

Clients may request in writing to see or obtain a copy of their records. Clients may request that correction is made if they identify errors or mistakes. Access to records will be made during regular business hours within 10 days of receipt request is written.

Use of Records

The practitioner will maintain records. No records or information shall be released without the written authorization of the clients, unless compelled by law.

Disclosure of Records

At no time are client records and information released to anyone without written request and release from the client, unless compelled by law (such as subpoenas).

I, (please print name) _____ have received, read and understand this privacy policy as it related to receiving Naturopathic and/or reflexology treatment from this practitioner.

_____

Patient Signature

_____

Date

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Client Consent Form

- Traditional Naturopathic Doctors (ND's) are not Medical Doctors (MD's)

- I understand that I should continue to see any medical doctors I am currently under the care of, and that any prescription medication should not be altered without first consulting the doctor who recommended it.

- I understand that I may be referred to another member of the health team to seek further care if deemed necessary.

- ND's are trained specialists who use non-invasive natural medicine, such as vitamins, minerals, herbs and dietary changes to create a healthy environment.

- Your visit today is based on the belief that the body has a natural ability to heal itself, if given an appropriate internal and external healing environment.

- Signs of physical, mental, supplemental deficiency or dietary stressors may be identified today. Information about traditional uses of supplementation that may create a healthy balance in the body may be discussed. This is not intended to be interpreted as a substitute for a licensed physician's treatment.

- I have read and discussed the above information and agree to the terms.

Signed _____ Date _____

Please print name _____

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Digestion and Bowel Patterns

Name:_____ **Date:**_____

1. Do you eat slowly with much chewing? Yes or No
2. Do you experience acid reflux Yes or No How often?_____
3. Do you experience heartburn or indigestion? Yes or No How often?_____
4. Do you use antacids such as Tums, Rolaids, Tagamet, Pepcid AC, Malox, etc? Yes or No How often?_____ Which One?_____
5. Do you experience bloating or discomfort after eating? Yes or No How Often?_____ Does it occur with specific foods? Yes or No
   Please name foods_____
6. Do you experience uncomfortable or frequent gas? Yes or No
   How often?_____
7. Do you take digestive enzymes? Yes or No
8. How many bowel movements do you have per day?_____ Weekly?_____
   Is stool firm (not hard) and shaped like a banana? Yes or No What color? Light brown Medium brown Other_____
9. Do you have to stimulate bowel movements with one of the following: Laxatives, herbs, glycerin suppositories, enemas, fiber, etc? Yes or No How often?_____
   For how long?_____ Which do you use?_____
10. Do you frequently experience diarrhea? Yes or No How often?_____
    Constipation?_____ How Often?_____
11. Have you ever done colon cleansing with enemas, colonics or herbs? Yes or No
    How often?_____ Which one?_____

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Sleep Patterns

Name:_____ **Date:**_____

1. Do you fall asleep easily? Yes or No
2. Do you wake up during the night? Yes or No How many Times?_____
3. If you wake up, do you go back to sleep easily? Yes or No

   If not, how long does it take you to go back to sleep. _____
4. Do you get up to urinate? Yes or No How many times?_____
5. How many hours per night do you sleep?_____
6. How many hours per night do you need to sleep?_____
7. How often do you dream? Rarely Often Never
8. Do you have frequent nightmares? Yes or No
9. Do you awaken refreshed? Yes or No
10. Do you take anything to help you sleep? Yes or No

    If yes, What?_____ How Often?_____ For how long?_____
11. Do you have any additional comments or concerns about your sleep pattern?

_____

_____

_____

_____

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Symptoms

Digestive:

- Belching
- Bloated
- Constipation
- Diarrhea
- Nausea
- Passing gas
- Stomach pains
- Vomiting

Ears:

- Drainage from ear
- Ear aches
- Ear infections
- Hearing loss
- Itchy ears
- Ringing in ears

Emotions:

- Aggressiveness
- Anxiety/fear
- Depression
- Irritability/anger
- Mood swings
- Nervousness

Energy:

- Apathy
- Fatigue
- Hyperactivity
- Lethargy
- Restlessness
- Sluggishness

Eyes:

- Blurred vision
- Dark circles
- Itchy eyes
- Sticky eyelids
- Swollen eyelids
- Watery eyes

Head:

- Dizziness
- Faintness
- Headaches
- Insomnia
- Lightheadedness

Joint & Muscles:

- Aches in muscles
- Arthritis
- Feeling of weakness
- Limited movement
- Pain in joints
- Stiffness

Lungs:

- Asthma
- Chest congestion
- Difficulty breathing
- Shortness of breath
- Wheezing

Cognition:

- Confusion
- Learning disabilities
- Poor concentration
- Poor memory
- Stuttering

Mouth & Throat

- Canker sores
- Chronic coughing
- Gagging
- Often clear throat
- Sore throat
- Swollen tongue/lips/gums

Nose:

- Excessive mucous
- Hay fever
- Sinus problems
- Sneezing attacks
- Stuffy nose

Skin:

- Acne
- Dermatitis
- Eczema
- Excessive sweating
- Flushing/hot flashes
- Hair loss
- Hives
- Rashes
- Itching

Weight:

- Binge eating
- Compulsive eating
- Cravings
- Excessive weight
- Underweight
- Water retention

Other:

- Anaphylactic reactions
- Chest pains
- Frequent illness
- Genital itch
- Irregular heart beat
- Rapid heart beat
- Urgent urination