

**A New Leaf Nutrition
Anne Fischer Silva
707-849-3569**

PLEASE PRINT

PERSONAL INFORMATION

NAME _____ DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ SOC. SEC. NO. _____ DATE OF BIRTH _____
MARITAL STATUS _____ SEX _____ AGE _____ NUMBER OF CHILDREN _____
OCCUPATION _____ EMPLOYER _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____
NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____
EMPLOYER _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

EMERGENCY NOTIFICATION

NAME _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____
REFERRED BY _____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

Date _____ Patient's Signature _____

CURRENT HEALTH CONDITION

Primary Purpose of this consultation: _____

Habits

- | | | |
|--|---|---|
| <input type="checkbox"/> Alcohol: Type _____
Amount _____
Diet: Salt intake _____
Fat intake _____
Other _____ | <input type="checkbox"/> Continuity disturbances _____
Early morning awakenings _____
Daytime drowsiness _____
Other _____ | <input type="checkbox"/> Exercise routine: _____
_____ |
| <input type="checkbox"/> Sleep: Difficulty falling
asleep _____ | <input type="checkbox"/> Smoking: Packs daily _____
How long _____
Interested in stopping? _____ | <input type="checkbox"/> Caffeine: Coffee, cups
daily _____
Other _____ |

MEDICATIONS: _____

DRUG ALLERGIES: _____

Medical History

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> RINGING IN EAR _____ | <input type="checkbox"/> GALL BLADDER TROUBLE _____ | <input type="checkbox"/> TREMOR/HANDS SHAKING _____ | MEASLES <input type="checkbox"/> RUBELLA <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> EAR INFECTIONS - FREQUENT _____ | <input type="checkbox"/> JAUNDICE/HEPATITIS _____ | <input type="checkbox"/> MUSCLE WEAKNESS _____ | <input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> HERPES |
| <input type="checkbox"/> DIZZINESS/FAINTING _____ | <input type="checkbox"/> CHANGE IN BOWEL HABITS _____ | <input type="checkbox"/> NUMBNESS/TINGLING SENSATIONS _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> FAILING VISION _____ | <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION _____ | <input type="checkbox"/> HEADACHES - FREQUENT _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> EYE INFECTIONS _____ | <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> CROHN'S/COLITIS _____ | <input type="checkbox"/> ARTHRITIS/RHEUMATISM _____ | Females - Please Complete |
| <input type="checkbox"/> NOSE BLEEDS _____ | <input type="checkbox"/> BLOODY OR TARRY STOOLS _____ | <input type="checkbox"/> OSTEOPOROSIS _____ | PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> SINUS TROUBLE _____ | <input type="checkbox"/> HEMORRHOIDS _____ | <input type="checkbox"/> BACK PAIN - RECURRENT _____ | PLANNING PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> SORE THROATS - FREQUENT _____ | <input type="checkbox"/> HERNIA _____ | <input type="checkbox"/> BONE FRACTURE/JOINT INJURY _____ | Menstrual Flow: |
| <input type="checkbox"/> HAYFEVER/ALLERGIES _____ | <input type="checkbox"/> URINE INFECTIONS - FREQUENT _____ | <input type="checkbox"/> GOUT _____ | <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps |
| <input type="checkbox"/> PNEUMONIA _____ | <input type="checkbox"/> BLOOD IN URINE _____ | <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> COLD NUMB FEET _____ | ____ Days of Flow ____ Length of Cycle |
| <input type="checkbox"/> BRONCHITIS/CHRONIC COUGH _____ | URINATION- <input type="checkbox"/> OVERNIGHT > THAN TWICE | <input type="checkbox"/> RASHES <input type="checkbox"/> HIVES _____ | Date-1st day of last period _____ |
| <input type="checkbox"/> ASTHMA/WHEEZING _____ | <input type="checkbox"/> PAINFUL <input type="checkbox"/> LOSS OF CONTROL | <input type="checkbox"/> PSORIASIS <input type="checkbox"/> ECZEMA _____ | <input type="checkbox"/> Pain/Bleeding during or after sex |
| <input type="checkbox"/> CHEST PAIN _____ | <input type="checkbox"/> DECREASE IN FORCE/FLOW | <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> DEPRESSION _____ | Number of: |
| <input type="checkbox"/> HIGH BLOOD PRESSURE _____ | <input type="checkbox"/> KIDNEY STONES _____ | <input type="checkbox"/> MEMORY LOSS _____ | ____ Pregnancies ____ Abortions |
| <input type="checkbox"/> HEART MURMUR _____ | <input type="checkbox"/> VENEREAL DISEASE _____ | <input type="checkbox"/> MOODINESS - EXCESSIVE _____ | ____ Miscariages ____ Live Births |
| <input type="checkbox"/> SWOLLEN ANKLES _____ | <input type="checkbox"/> URETHRAL DISCHARGE _____ | <input type="checkbox"/> PHOBIAS _____ | Birth Control Method _____ |
| <input type="checkbox"/> LEG PAIN - WALKING _____ | <input type="checkbox"/> CHRONIC FATIGUE _____ | <input type="checkbox"/> MENTAL ILLNESS _____ | B.C. Pill (Name) _____ |
| <input type="checkbox"/> VARICOSE VEINS/PHEBITIS _____ | <input type="checkbox"/> WEIGHT LOSS - RECENT _____ | <input type="checkbox"/> LACTOSE INTOLERANCE _____ | <input type="checkbox"/> Flushing/Menopause |
| <input type="checkbox"/> LOSS OF APPETITE _____ | <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY _____ | <input type="checkbox"/> PROSTATE DISEASE _____ | Date of Last PAP Test _____ |
| <input type="checkbox"/> DIFFICULTY SWALLOWING _____ | <input type="checkbox"/> CANCER _____ | <input type="checkbox"/> SEXUAL/MENSTRUAL DYSFUNCTION _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> INDIGESTION OR HEARTBURN _____ | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> FREQUENT INFECTIONS _____ | Date of Last Mammogram |
| <input type="checkbox"/> PERSISTENT NAUSEA/VOMITING _____ | <input type="checkbox"/> THYROID DISEASE _____ | <input type="checkbox"/> DIPHTHERIA _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> PEPTIC ULCERS _____ | <input type="checkbox"/> CONVULSIONS/SEIZURES _____ | <input type="checkbox"/> TETANUS _____ | |
| <input type="checkbox"/> ABDOMINAL PAIN - CHRONIC _____ | <input type="checkbox"/> STROKE _____ | <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> POLIO <input type="checkbox"/> MUMPS <input type="checkbox"/> | |

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER	_____	_____	_____	DIABETES	_____
MOTHER	_____	_____	_____	CANCER	_____
BROTHERS AND SISTERS	_____	_____	_____	BLOOD DISEASE	_____
	_____	_____	_____	GLAUCOMA	_____
	_____	_____	_____	EPILEPSY	_____
SPOUSE	_____	_____	_____	RHEUMATOID	_____
	_____	_____	_____	ARTHRITIS	_____
CHILDREN	_____	_____	_____	TUBERCULOSIS	_____
	_____	_____	_____	GOUT	_____
	_____	_____	_____	HIGH BLOOD PRESSURE	_____
	_____	_____	_____	HEART DISEASE	_____
	_____	_____	_____	BACK PROBLEMS	_____

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