

JAM NATUROPATHICS

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Client History

Name _____ Date _____

Date of Last Physical Exam _____ Physician's Name _____ Blood Type _____

Major Complaints and Symptoms You Are Experiencing _____

Do these complaints interfere with your normal living or work Yes No

Were these complaints caused by Fall Strain Accident Emotional Shock Other _____
Any other health problems _____

List All Prescribed Medications/Drugs or OTC Products _____

List All Herbal/Homeopathic Remedies _____

Have you used or do you use tobacco products Yes No Which Cigarettes Cigar Pipe Chewing/Smokeless
For how many years _____ How much daily _____

Do you drink alcoholic beverages Yes No Number Daily _____ Number Weekly _____

Do you drink carbonated beverages Yes No Number Daily _____ Number Weekly _____

Please check which carbonated beverages you drink Regular Diet Club Soda/Seltzer Mineral Water

Are you pregnant Yes No Which trimester 1st 2nd 3rd

Do you color your hair Yes No Do you perm or straighten your hair Yes No How often _____

Please list the types of food you eat on a regular basis and any cravings _____

Please list all types and amounts of beverages you drink daily and the frequency of your urination _____

How often do you have a bowel movement and its consistency _____

What is your emotional status _____

MEDICAL HISTORY Please circle all of the following that you have or have had; if chronic or recurring, please mark with a C:

- | | | |
|----------------------|------------------------|----------------------|
| Allergy | Arterial Problems | Arthritis/Stiffness |
| Asthma | Bladder Infections | Bowel Problems |
| Bronchitis | Bruise Easily | Bursitis |
| Cancer | Carpal Tunnel Syndrome | Chest Pain |
| Chickenpox | Chills | Cold Hands/Feet |
| Colitis | Constipation | Convulsions |
| Cough | Depression | Diabetes |
| Diarrhea | Difficulty Digesting | Dizziness |
| Ear Infections | Ear Noises | Emphysema |
| Epilepsy | Exema | Faintings |
| Fatigue | Fever | Fibromyalgia |
| Foot Problems/Injury | Frequent Colds | Frequent Ear Aches |
| Frequent Vomiting | Gallbladder Problems | Hay Fever |
| Headaches/Migraines | Heart Problems | High Blood Pressure |
| Hoarseness | Hemorrhoids | Hot Flashes |
| Hypoglycemia | Itching/Dryness | Leg/Arm Injury |
| Liver Problems | Loss of Balance | Loss of Sleep |
| Loss of Smell | Loss of Taste | Low Back Pain/Injury |
| Low Blood Pressure | Measles | Metal Implants |
| Mid Back Pain/Injury | Multiple Sclerosis | Mumps |
| Nausea | Neck Pain/Injury | Nervousness |
| Numbness in Fingers | Numbness in Toes | PMS |
| Shortness of Breath | Shoulder Pain | Sinus Infection |
| Strain/Sprain | Strep Throat | Swollen Joint |
| Thyroid Problems | Tingling in Arms | Tingling in Legs |
| Tremors | TMJ Pain/Problems | Tuberculosis |

Neurological Disorder Which one _____ When Diagnosed _____

Symptoms or problems other than above _____

List all surgeries and dates _____

The above information is, to the best of my knowledge, true and factual.

Signature _____ Date _____

