Kiera Lane, N.M.D., P.L.L.C.
Naturopathic Physician

"Integrative Health Care for the Body and Mind"

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DATE _____

PATIENT PROFILE

NAME _____ **AGE** _____ **BIRTHDATE** _____ **SEX** ☐ F ☐ M

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE _____ **WORK PHONE** _____ **OTHER PHONE** _____

OCCUPATION _____ ☐ **FULL TIME** ☐ **PART TIME** ☐ **RETIRED**

EMPLOYER'S NAME & ADDRESS _____

DRIVER'S LICENSE # _____ **ISSUING STATE** _____

SOCIAL SECURITY # _____ **EDUCATION** _____

EMERGENCY CONTACT _____ **RELATIONSHIP** _____

ADDRESS _____ **PHONE** _____

INSURANCE COMPANY _____ **POLICY #** _____

NAME OF PERSON INSURED _____

_____

REFERRED BY _____

_____

A NOTE TO OUR PATIENTS: Naturopathic, holistic, and preventive health care are only possible when the physician has a complete picture of the patient - physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. *Thank you.*

In your opinion, what are your most important health problems?

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

What health problems do you want to talk about today? List in order of importance.

1) _____ 3) _____
2) _____ 4) _____

YOUR HEALTH HISTORY: Please check the relevant areas and give some details below.

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Colitis
☐ Diabetes
☐ Gout
☐ Heart Disorders
☐ Herpes Genitalis
☐ High Blood pressure
☐ Hypoglycemia
☐ Injury (serious)
☐ Liver Disorders
☐ Psychological Disorders
☐ Skin Disorders
☐ Stroke
☐ Thyroid Disorders
☐ Tuberculosis
☐ Venereal Disease

Other _____

_____

HOSPITALIZATIONS: (Dates and type of illness/operation)

KNOWN ALLERGIES: (to medications, foods, pollens, etc.)

MEDICATIONS & SUPPLEMENTS: (include prescription and non-prescription items, herbs, vitamins, minerals, etc.)

HEALTH HABITS:

Primary interests, hobbies, or activities:

Do you get regular exercise? ☐Yes ☐No. What form?

How often?

Do you drink alcohol? If so, how much, how often, and what kind?

Do you use other recreational drugs? If so, what kind and how often?

Do you use tobacco? If so, what kind, how much, and for how long have you used it?

Do you drink coffee? If so, how much?

How many meals do you generally eat per day? How many snacks?

What kinds of foods make up your primary diet?

What kinds of foods do you usually exclude form your diet?

FAMILY HISTORY: (check YES, NO, or DK (don't know) for blood relatives)

YES	NO	DK		YES	NO	DK		YES	NO	DK	
			Alcoholism				Gout				Sickle Cell Anemia
			Anemia				Hay Fever				Skin Disorders
			Asthma				Heart Disease				Stroke
			Hemophilia				High Blood Pressure				Thyroid Disorders
			Cancer				Hypoglycemia				Tuberculosis
			Diabetes				Mental illness				Venereal Disease
			Glaucoma				Seizure or epilepsy				

Any other significant family health problems?