SUNDANCE NATURAL MEDICINE Assessment Form

First Office Call:

Client Name _____ ◯ Male ◯ Female

Address _____ Date of Birth: _____

E-Mail Address _____ Phone #: _____ Alt. Phone #: _____

Overall Health:

In general, compared to other persons my age, I would rate my health as:

◯ Excellent ◯ Good ◯ Average ◯ Fair ◯ Poor

List three adjectives that describe you as a person: _____

Have you ever been under the care of a psychiatrist, or undergone counseling? ◯ Yes ◯ No

If yes, please provide details: _____

Any of these signs or symptoms?

- ☐ Increased thirst, frequent urination
- ☐ Increased hunger
- ☐ Weight loss
- ☐ Fatigue or a feeling of being tired more often than usual
- ☐ Blurry vision
- ☐ Areas of darkened skin
- ☐ Slow healing sores or frequent infections
- ☐ Dry mouth

Check all health conditions that currently apply to you, or that you've had in the past:

- ☐ Heart Disease (Irregular heart beat, high blood pressure, congestive heart failure, cardiomyopathy)
- ☐ Peripheral Vascular Disease
- ☐ Under functioning or over functioning thyroid
- ☐ Kidney or liver failure, or other malfunctions
- ☐ Lung Disease (pneumonia, bronchitis, asthma, chronic obstructive pulmonary disease)
- ☐ Arthritis
- ☐ Lupus
- ☐ Migraines or headaches
- ☐ Depression, situational
- ☐ Weight loss / gain (past three years)
- ☐ Parkinsons
- ☐ Diabetes, adult onset 2
- ☐ Juvenile Diabetes
- ☐ Autoimmune Disease
- ☐ Major Depression
- ☐ Bipolar Disorder
- ☐ OCD (Obsessive Compulsive Disorder)
- ☐ Deep Vein Thrombosis
- ☐ Intermittent Claudication
- ☐ Impotence/Low Libido
- ☐ STD (Sexually Transmitted Disease(s)) ☐ HIV/AIDS
- ☐ Panic attacks
- ☐ Chronic back pain
- ☐ Mental illness
- ☐ Allergies
- ☐ Musculoskeletal problems that limit your physical activity
- ☐ Stroke (cerebrovascular accident)
- ☐ Digestive disorder (esophagus, stomach, small or large intestines
- ☐ Cancer, if so, primary site: _____

ASSESSMENT FORM *(continued)*

Do you take any prescriptive medication(s)?

Please list:

Alcohol Use: Frequency: Type:

Cigarette Use: How long: How many per day:

Date of last blood test(s): *(cholesterol, CBC, glucose, thyroid, comprehensive metabolic profile)*

Date of last physical exam:

For men: Did this include a digital prostate exam? ◯ Yes ◯ No

For women: Did this include a pap smear, breast exam, mammogram? ◯ Yes ◯ No

Last blood pressure check:

Current weight: Do you consider yourself overweight according to your standards? ◯ Yes ◯ No

In a typical week, how often do you include exercise in your daily activities?

What form(s) of exercise do you do?

- ☐ Aerobics
- ☐ Classes (floor mats, power lifting, kickboxing, etc.)
- ☐ Weight lifting
- ☐ Walking
- ☐ Swimming
- ☐ Other:

◯ Regular/Consistent? ◯ Inconsistent?

Hospitalization:

In case of emergency, do you have a hospital preference? ◯ Yes ◯ No

If yes, please specify which hospital:

Emergency Contact: Phone #:

Address: Alt. Phone #:

Print Form

Sundance Natural Medicine

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