



# Arizona Natural Medicine, L.L.C.

Kiera Lane, N.M.D., L.Ac.

Sarv Varta K. Khalsa, N.M.D.

2480 W. Ray Road, Suite 1 ~ Chandler, AZ 85224 ~ P (480) 722-2811 ~ F (480) 722-2817

[info@ArizonaNaturalMedicine.com](mailto:info@ArizonaNaturalMedicine.com)

<http://www.ArizonaNaturalMedicine.com>

Date \_\_\_\_\_

## PATIENT PROFILE

NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX  F  M

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_  FULL TIME  PART TIME  RETIRED  STUDENT

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.

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Liver Disorders         |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Gout                | <input type="checkbox"/> Psychological Disorders |
| <input type="checkbox"/> Anemia     | <input type="checkbox"/> Heart Disorders     | <input type="checkbox"/> Skin Disorders          |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Herpes Genitalis    | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Thyroid Disorders       |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Colitis    | <input type="checkbox"/> Injury (serious)    | <input type="checkbox"/> 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 ? (don't know) for blood relatives)

YES	NO	?		YES	NO	?		YES	NO	?	
			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? \_\_\_\_\_

---



---