PATIENT PROFILE

Date: ________________

Please complete this questionnaire as *thoroughly* as possible in order to aid in your diagnosis and treatment. This is a confidential record and will not be released without your authorization to do so.

Name ______________________________ Age ___ Birthdate _______

Male ☐ Female ☐

Address ____

Postal Code______________

Phone (home) _______________________(work) ________________

Email: ____

Occupation ____

Full-time ☐ Part-time ☐

Emergency Contact ___________________________ Phone # _______

How did you hear about our clinic? ______________________________

PRESENT HEALTH CONCERNS

Please list your present health concerns, in order of significance.

1. ____
2. ____
3. ____
4. ____

MEDICAL HISTORY

Have you ever had *or* currently have any of the following:

Allergies	☐	Headaches	☐
Alcoholism	☐	Heart Disease	☐
Anemia	☐	Hepatitis	☐
Asthma	☐	Kidney Disease	☐
Autoimmune Dz	☐	Mental Illness	☐
Cancer	☐	Stroke	☐
Diabetes	☐	Tuberculosis	☐
Epilepsy	☐	Other ____________	☐

Surgeries ____

____

Major Accidents ____
____
Hospitalizations ____
____
Medications ____
Vitamins/Minerals ____
Herbs or Homeopathics ____

ALLERGIES:

Drugs ____
Food ____
Environmental (grasses, pollens, etc.) ____________________

Last complete Physical Exam Month __________ Year ________
Dr. ________________

FOR WOMEN

Last Pap Smear Month __________ Year ________ Dr. ________
Results? ❑ Normal ❑ Abnormal (please specify) ____________

PERSONAL HABITS

Check if you use any of the following:
❑ Tobacco ❑ Caffeine ❑ Alcohol ❑ Recreational Drugs

Are there any diet restrictions or regimens that you follow? If yes, please describe ____
____

How many hours of sleep do you get? ____________________
Sleep difficulties? ________________________________
Do you have a regular exercise program? If yes, please describe ________
____

SOCIAL HISTORY

Single ❑ Married ❑ Significant Other ❑ Years ____________
Children: No ❑ Yes ❑ How many ________ Age(s) ____________

MEDICAL SYMPTOMS QUESTIONAIRE

Patient Name:________________________Date:________

Rate each of the following symptoms based upon your typical health

Point Scale

- ***0*** ***Never*** *or* ***Almost never*** *have the symptom*
- ***1*** ***Occasionally*** *have it, effect is* ***not severe***
- ***2*** ***Occasionally*** *have it, effect is* ***severe***
- ***3*** ***Frequently*** *have it, effect is* ***not severe***
- ***4*** ***Frequently*** *have it, effect is* ***severe***

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total ___

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near- or far-sightedness)

Total___

EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total___

NOSE

___ Stuffy nose
___ Sinus Problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total___

THROAT

___ Chronic Coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen or discolored tongue, gums, lips
___ Canker sores

Total___

SKIN

___ Acne
___ Hives, rashes, dry skin
___ Hair loss
___ Flushing, hot flashes
___ Excessive sweating

Total___

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total___

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing

Total___

GI

- ___ Nausea, vomiting
- ___ Diarrhea
- ___ Constipation
- ___ Bloated feeling
- ___ Belching, passing gas
- ___ Heartburn
- ___ Intestinal/stomach pain

Total___

JOINTS MUSCLE

- ___ Pain or aches in joints
- ___ Arthritis
- ___ Stiffness or limitation of movement
- ___ Pain or aches in muscles
- Feeling of weakness or tiredness

Total___

GENITOURINARY

- Frequent or urgent urination
- ___ Incontinence
- ___ Difficult urination, hesitancy
- ___ Genital itch or discharge
- ___ Irregular menses
- ___ Painful menses
- ___ Discomfort before, after or during period

Total___

ENERGY

- ___ Fatigue, sluggishness
- ___ Apathy, lethargy
- ___ Hyperactivity
- ___ Restlessness

Total___

MENTAL

- ___ Poor memory
- ___ Confusion, poor comprehension
- ___ Poor concentration
- ___ Poor physical co-ordination
- ___ Difficulty in making decisions
- ___ Stuttering or stammering
- ___ Slurred speech
- ___ Learning disabilities

Total___

EMOTIONS

- ___ Mood swings
- ___ Anger, fear, nervousness
- ___ Anger, irritability, aggressiveness
- ___ Depression

Total___

OTHER

- ___ Frequent illness
- ___ Swollen lymph nodes

Total___

DECLARATION AND CONSENT TO TREATMENT

Patient's Name ______________________________ Date __________

I. **This is to acknowledge that I have been informed that :**

i. Any treatment or advice provided to me as a patient of Dr. Jennifer Burns, ND, is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future from another licensed health care provider.

ii. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider, qualified to practice in Arizona.

iii. No employee, agent or anyone else under this clinic's direction or control is suggesting or recommending to me to refrain from seeking or following the advice of another licensed health care provider.

iv. The treatment and therapies rendered or recommended by this clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

II. I declare that I have received a full and complete explanation of the treatment or services that I may receive from Dr. Burns and hereby authorize and consent to treatment.

III. I agree to pay my full account at the time of each visit or treatment, including fees or services, cost of supplement and remedies, cost of laboratory tests and other fees.

____
Patient or Guardian's Signature