

Date _____

Name _____

Age/ DOB _____

Address _____

Phone (Home) _____

City _____ State _____ Zip _____

E-mail address _____

Phone (Work) _____

Check this box to receive updates on exciting promotions, events and more.

Phone (Cell) _____

How did you hear about vir tú? _____

Is it acceptable for us to contact you via e-mail? Yes No

Is it acceptable for us to leave messages on a voice mail/answering machine for you? Yes No

How did you hear about vir tú? _____

Please list your major health concerns, listing the most important concern first. _____

What treatments have you tried for the above concerns? _____

When was your most recent blood work and with what physician? _____

Family History

	Mother	Father	Grandparents	Siblings
Age if living				
Age if deceased				
Cause of death				



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Do you have a family history of any of the following diseases? (Check those that apply).

	Mother	Father	Grandparents	Siblings
Diabetes				
High Blood Pressure				
Heart Attack/Stroke				
Asthma/Allergies				
Cancer				
Other				

Please list all surgeries and hospitalizations, including date of occurrence.

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

Please list all medications, vitamins, supplements, hormones, and other prescriptions you currently take. Include dosage if known.

Please list ALL your known allergies (drug, food, insect, animal, etc).

Review of Systems

Present Weight _____ Weight One Year Ago _____ Height _____ Ideal Weight _____

For the section below, please circle Y if you currently have the problem and N if you do not have the problem.

ENERGY

Good Energy	Y	N		
Fatigue	Y	N		
If you have fatigue, is it worse in the morning, afternoon or evening? _____			If you have fatigue, are you able to complete your daily tasks? Y N	
			Overall, please rate your energy level on a scale from 1 – 10 (1 being low and 10 being high). _____	

HEAD

Headaches	Y	N
Hair Loss	Y	N
Migraines	Y	N
Dry Scalp	Y	N

EYES

Blurry Vision	Y	N
Dry	Y	N
Itchy	Y	N
Dark Under Eyelid	Y	N

NOSE

Frequent Colds	Y	N
Seasonal Allergies	Y	N
Congestion	Y	N
Nosebleeds	Y	N

MOUTH/THROAT

Sore Throat	Y	N
Voice Hoarse	Y	N
Cold Sores	Y	N
Canker Sores	Y	N

RESPIRATORY

Cough	Y	N
Painful Breathing	Y	N
Shortness of breath	Y	N
Bronchitis	Y	N
Asthma	Y	N
Pneumonia	Y	N

CARDIOVASCULAR

High Blood Pressure	Y	N
Murmurs	Y	N
Low Blood Pressure	Y	N
Palpitations	Y	N
Chest Pain	Y	N
Edema	Y	N



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URINARY TRACT

Incontinence	Y	N
Pain w/ urination	Y	N
Frequent Infections	Y	N
Kidney Stones	Y	N
Urgency	Y	N
Blood/Discharge	Y	N

GASTROINTESTINAL

Heartburn	Y	N
Bowel Movements per day _____		
Indigestion	Y	N
Recent BM Change	Y	N
Bloating	Y	N
Diarrhea	Y	N
Nausea	Y	N

MENTAL/EMOTIONAL

Depression	Y	N
Anxiety	Y	N
Suicidal	Y	N
Angry/Irritable	Y	N
Eating Disorder	Y	N
Fear/Panic	Y	N

MUSCULOSKELETAL

Joint Pain	Y	N
Arthritis	Y	N
Back Pain	Y	N
Leg Cramps	Y	N
Neck Pain	Y	N
Stiffness	Y	N

Constipation	Y	N
Vomiting	Y	N
Blood/Mucus in stool	Y	N
Change in appetite	Y	N
Hemorrhoids	Y	N
Liver Disease	Y	N
Gall Bladder Disease	Y	N

MALE ONLY

Testicular Pain/Swelling	Y	N
Sexually Active	Y	N
Frequent Urination	__day	__night
S.T.D.	Y	N
Last Prostate Exam/PSA Evaluation	_____	



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FEMALE ONLY

Age period began _____

Menstrual Cramps Y N

Duration of periods _____

Heavy Bleeding Y N

How often period occurs _____

PMS Y N

Number of births _____

Food Cravings Y N

Number of pregnancies _____

Abnormal Pap Smear Y N

Number of miscarriages _____

Use of hormones Y N

SLEEP

Sleep Soundly Y N

Wake Rested Y N

Feel Restless at Bedtime Y N

Wake Easily at Night Y N

Hours per night _____

Snore Y N

Circle Yes (Y), No (N), or Past (P) regarding your use of the following:

Smoking Y N P

Coffee Y N P

Soda Pop Y N P

Alcohol Y N P

Analgesics Y N P

Laxatives Y N P

Menopausal _____

Sexually Active Y N

Dry Vagina Y N

Healthy Libido Y N

Mammography Y N

Pain with intercourse Y N

Dexa Scan Y N

S.T.D. Y N

Hot Flashes Y N

Hair growth on face Y N

Please list any birth control used and ages used. _____

EXERCISE

Frequency of exercise _____

Type of exercise _____

Duration _____

Active Hobbies _____

Packs per day and number of years _____

Cups per day _____

Ounces per day _____

Frequency and amount _____

Steroids Y N P



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SOCIAL LIFE

Enjoy Job Y N

Hours worked per week _____

Highest level of education _____

Active spiritual practice Y N

Marital Status S M D W

Hobbies _____

Quality of significant relationship _____

What is your greatest health concern? _____

How does it limit you the most? _____

How committed are you to making valuable changes?

Little Moderately Very

TYPICAL DAILY DIET

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids _____