

# DR. IAN CHOLEWA, ND NATURAL HEALTH CLINIC

Date: \_\_\_\_\_

## PERSONAL INFORMATION

<b>Last Name:</b>	<b>Mailing Address:</b>		
<b>First Name:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>How would you prefer to be addressed in our office?</b>	<b>Work Phone:</b>		
	<b>Home Phone:</b>		
<b>Birth Date:</b>	<b>E-mail/Fax:*</b>		
<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Occupation:</b>		
<b>Emergency Contact Name:</b>	<b>Do You Have Health Insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Relationship:</b>	<b>Phone:</b>	<b>If Yes, Please Name:</b>	
<b>Parent or Guardian Name (if child):</b>	<b>Referred By:</b>		

\*Please provide us with your e-mail address/Fax number above to receive information on our educational events.

## MEDICAL HISTORY

**A Note to Our Patients:** Please complete this form as thoroughly as possible. This is a confidential record of your medical history and will not be released, except with your written authorization. Thank you.

### PRESENT HEALTH CONCERNS

PRESENT COMPLAINT (Please list with <u>most important first</u> )	HOW LONG	RELEVANT HISTORY	Doctor Use Only
<u>Example:</u> Headache	7 days	Since getting the flu	
<b>1.</b>			
<b>2.</b>			
<b>3.</b>			
<b>4.</b>			

**PLEASE LIST OTHER COMPLAINTS:**

**HAS ANYTHING RECENTLY CHANGED OR BECOME WORSE?**

### SUPPLEMENTS AND MEDICAL DRUGS

CURRENT NATURAL SUPPLEMENTS:	CURRENT MEDICAL DRUGS:
<b>1.</b>	<b>1.</b>
<b>2.</b>	<b>2.</b>
<b>3.</b>	<b>3.</b>
<b>4.</b>	<b>4.</b>
<b>5.</b>	<b>5.</b>
<b>6.</b>	<b>6.</b>
<b>7.</b>	<b>7.</b>

## MAJOR ILLNESSES AND ACCIDENTS

DATE	ILLNESS OR ACCIDENT

## FAMILY HEALTH HISTORY

RELATIVE	AILMENT
<b>Father</b>	
<b>Mother</b>	
<b>Sister</b>	
<b>Brother</b>	

## ALLERGIES

TYPE	ALLERGEN
<b>Food</b>	
<b>Environmental</b>	
<b>Other</b>	

<b>ANYTHING ELSE I NEED TO KNOW?</b>

## YOUR PRIMARY DOCTORS

<b>MD</b>	
<b>DC</b>	
<b>L.Ac.</b>	

HAVE YOU HAD ANY OF THESE CONDITIONS IN THE LAST 5 YEARS?

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Gum/Teeth Problems | <input type="checkbox"/> Back, Muscle, Joint Pain | <input type="checkbox"/> Hives / Rash           | <input type="checkbox"/> Recurrent Colds    |
| <input type="checkbox"/> Root Canals        | <input type="checkbox"/> Bladder/Urinary Problems | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Food Allergies     |
| <input type="checkbox"/> Tonsillitis        | <input type="checkbox"/> Neck / Back Pain         | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Hay Fever          |
| <input type="checkbox"/> Eyes Problems      | <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Yeast Infections         | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Chemical Allergies |
| <input type="checkbox"/> Headache           | <input type="checkbox"/> Candida                  | <input type="checkbox"/> Heart Problems         | <input type="checkbox"/> STD's              |
| <input type="checkbox"/> Ear Problems       | <input type="checkbox"/> Skin Problems            | <input type="checkbox"/> Liver Problems         | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> Gynecological Problems | <input type="checkbox"/> Other: _____       |

## CONSENT TO USE ELECTRO-DIAGNOSTIC METHODS

I understand that Dr. Ian Cholewa is a Naturopathic Physician licensed in the state of Hawaii. That he has extensive training in the use of Electrodermal Testing Instruments and is using the data from these tests to investigate a functional assessment of my condition, (not a pathological diagnosis). That the collection of these data may be used in research being conducted by the AANP (American Association of Naturopathic Physicians) position paper titled Electrodiagnosis in Naturopathic Practice under the bylaws of the AANP.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_