First Time Appointment Form

Dr. Sue Massie, ND

HEALTH HISTORY

NAME DATE

ADDRESS

CITY/STATE/ZIP

PHONE EMAIL

AGE SEX HEIGHT WEIGHT

Describe what you eat in a day.

BREAKFAST

LUNCH

DINNER

SNACKS

Fluids in a day.

WATER TEA/COFFEE SODA

JUICE OTHER

How much sleep do you get on average?

Do you wake up and if so, what time?

Do you wake to urinate? Is it urgent?

How many bowel movements do you have per day?

Describe your energy level

Are you taking medications?

What for?

****DO NOT STOP TAKING ANY MEDICATIONS WITHOUT YOUR DOCTOR'S ORDERS****

_____ INITIAL HERE

List any surgeries you've had

Do you exercise?

Do you currently have problems with:

_____ allergies

_____ leg cramps

_____ constipation

_____ high blood pressure

_____ depression

_____ PMS/menopause concerns

_____ fluid retention

_____ mood swings

_____ high cholesterol

_____ headaches

_____ dizzy spells

_____ digestive problems

_____ nervous tension

_____ blood sugar problem

_____ breathing problems

_____ joint aches

_____ skin problems

_____ heart problems

Do you have cravings for:

_____ chocolate

_____ sugar

_____ crunchy

_____ peanut butter

_____ salt

What is your main concern today?