

Clients Name: _____

**Gabriele Wolf Natural Health Practice
210-859-6600**

Name: _____ Today's Date: _____
Home Phone: _____ Cell Phone: _____
E-mail Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ SS#: _____
Sex: M _____ F _____ Height: _____ Weight: _____ Referred by: _____
Marital Status: MSDW Number of Children: Boys _____ Girls _____

Employer: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Work Phone: _____ Years at Job: _____

Name of Spouse: _____ Birth Date: _____

Emergency Contact Name _____ Relationship _____
Address _____ Phone: _____

Major complaints: _____

PAYMENT IS DUE AT THE TIME OF SERVICE

Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance.

Clients Signature: _____ Date: _____

Spouse or Guardians Signature: _____ Date: _____

Consent to treatment

I _____ hereby consent, authorize and request _____
The treatment deemed advisable and necessary to my (my wards) condition in accordance with her expertise. I agree to hold her free and harmless from any claim, suits for damage or complications which may result from treatment.

Clients Signature _____ Print Name _____ Date _____

Witness Signature _____ Print Name _____ Date _____

Clients Name _____

Family History

Parents living: Father (age) _____ Mother (age) _____

Brothers: _____ Sisters: _____

Is there any family history of the following?

Diabetes _____ Asthma _____ Cancer _____ Mental Disease _____

Heart Disease _____ Lung Disease _____ Arthritis _____ Allergies _____

Any other (specify) _____

Personal History

Childhood Diseases: Measles _____ Mumps _____ Chickenpox _____

Unusual Childhood Diseases: _____

Do you smoke? _____ How many? _____ Drink coffee? _____ How much? _____

Do you drink alcohol? _____ How much? _____

Do you take any drugs? _____ List names _____

Do you take any Vitamins? _____ List names _____

Do you exercise? _____ Regular _____ Infrequently _____ Seldom _____

Are you pregnant now? _____ Last menstrual period _____

Hobbies if any _____

Past History:

List any significant injuries (slips, falls, auto accidents, etc.) and give dates: _____

List any of your current health problems: _____

List any past significant illness: _____

List all surgeries (give dates) _____

List any known allergies: _____

List all abnormalities: _____

Clients Name: _____

If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally, etc.: _____

Would you say you are under a lot of stress? _____ If yes, explain: _____

Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.: _____

Women: Do you experience any pain or discomfort before, during, or after your menstrual cycle? Do you experience any pain or discomfort during the cycle week, regardless or whether you menstruate, are in menopause, skip your period periodically, or have had surgical removal of parts or all of the reproductive organs? During the cycle week are you grouchy? Irritable? Have crying spells? Feel uptight, more nervous or any other specific problems? _____

Chief complaints: _____
Describe present condition: _____

Duration of present condition: _____
What do you believe caused this condition? _____

When were you last seen by a physician? _____
For what purpose? _____

Your doctor's name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number; _____ Significant diagnosis by your doctor: _____

List all food and beverages taken more than three times per week: _____

