Today's Date: _____

PATIENT INFORMATION (Please print in block letters)

Name: _____ _____ _____
First name Middle name Last name

By what name do you prefer for us to call you? _____

Date of Birth (MM/DD/YYYY): _____ Current Age: _____ Sex: _____

Address: _____ _____
Street address Apartment #

_____ _____ _____
City Postal code Province

Please provide your contact information below & indicate whether or not we may leave messages relating to your appointments:

		Message?			Message?
(H) phone			Cell		
(W) Phone			E-mail		

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to you: _____

Phone numbers: H: ( ) _____ OTHER: ( ) _____

HOW DID YOU HEAR ABOUT DR. BENNA LUN, ND?

☐ Website
☐ Passing by clinic
☐ Seeing another health practitioner in this clinic
☐ Referred by another patient
☐ Referred by clinic staff member
☐ Referred by health care provider: _____
☐ Other (please specify: _____ _____

HEALTH CARE PROVIDERS **(continued on next page)**

Do you have regular screening tests with a doctor (e.g. blood tests, PAP, etc.)? (Please circle) Yes No

Please list the other health care providers from whom you currently receive treatment (fill out as best you can):

Name: _____ Name: _____

Type of care: _____ Type of care: _____

Address: _____ Address: _____

_____ _____

Phone: ( )_____ Phone: ( )_____

HEALTH CARE PROVIDERS (continued)

Name: _____ Name: _____

Type of care: _____ Type of care: _____

Address: _____ Address: _____

_____ _____

Phone: ( )_____ Phone: ( )_____

CHIEF CONCERNS

Please list the top health care concerns for which you are seeking treatment in order of importance to you:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

MEDICAL HISTORY

How is your general state of health? (Please circle) Excellent Good Average Fair Poor

Please list any past health concerns (e.g. major illnesses, hospitalizations, surgeries) with approximate dates:

1. _____

2. _____

3. _____

4. _____

Do you have any allergies (medication, seasonal, environmental, etc.)?

(Please circle) Yes No

If yes, please describe: _____

_____

If you are female, are you currently pregnant or are hoping to become pregnant within the next 1-2 years?

(Please circle) Yes No

MEDICATIONS & SUPPLEMENTS

CURRENT prescription medications			
Drug name	Date started	Dose	What is this drug being taken for?
PAST prescription medications *(within the past 1-2 yrs or longer)*			
Drug name	Date ended	Dose	What was this drug being taken for?
CURRENT supplements (including vitamins, minerals, herbs, homeopathics, etc.)			
Supplement name	Date started	Dose	What is this supplement being taken for?

Over-the-counter (non-prescription medications) (e.g. for pain, allergies):

_____

_____

	Amount you consume/use per day or week or month
Caffeine (e.g. coffee, chocolate, green/black tea)	
Tobacco (e.g. cigarettes, chewing tobacco)	
Alcohol (e.g. beer, wine, liquor)	
Recreational drugs (e.g. marijuana, cocaine, heroin)	

IMMUNIZATION HISTORY

Is there anything remarkable about your immunization history? Please describe: _____

_____

Have you ever experienced a negative reaction from an immunization, including the "flu" shot? Please describe:

_____

_____

DIET

Please list examples of what you typically consume:

Breakfast: _____

_____

Lunch: _____

_____

Supper: _____

_____

Snacks: _____

Beverages: _____

How is your food usually prepared? (Please circle) Home-made Purchased Both

Do you have any food allergies, sensitivities, or intolerances (that you know of)? Yes No

Please describe: _____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? Yes No

Please describe: _____

FAMILY MEDICAL HISTORY

Please indicate any health conditions occurring in your family. Include parents, siblings, children, grandparents, aunts, and uncles and specify paternal / maternal lineage.

Health condition	Family member(s)
Asthma	
Allergies (e.g. environmental, seasonal, food)	
Skin condition (e.g. eczema, psoriasis)	
Heart disease (e.g. heart attack, stroke, high blood pressure, high cholesterol)	
Diabetes	
Thyroid disease (Low or High functioning?)	
Joint condition (e.g. arthritis, rheumatism)	
Auto-immune disease (e.g. multiple sclerosis, lupus)	
Cancer (Please indicate type)	
Mental illness (e.g. anxiety, depression, schizophrenia)	
Other (please describe):	

☐ I don't know my family medical history

LIFESTYLE

What is your current occupation? _____

Past occupation(s) of significance? _____

What are your hobbies?_____

_____

Please describe types and amounts of physical activities (including exercise): _____

_____

_____

_____

LIVING ENVIRONMENT

Are you exposed to significant amounts of smoke (including tobacco smoke) or other forms of pollution through work, hobbies, home environment, etc.? (Please circle) Yes No

Please describe: _____

_____

Are you frequently exposed to animals (including pets)? (Please circle) Yes No

Please describe: _____

_____

How would you describe the emotional environment in your household? _____

_____

_____

_____

_____

How stressful is your work and other aspects of your life? _____

_____

_____

_____

_____

How well do you feel you handle stress? _____

_____

_____

_____

Is there anything you feel is important that has not been covered? _____

_____

_____

_____

Thank you for taking the time to complete this form