Dr. Liz Cavin Naturopathic Doctor
1075 N. Rodney St.; Ste 108 - Helena MT 59601 - Phone 406-996-1223 lizcavin@lizcavinnaturopath.com

Name _____ Birthdate: _____ Age _____ Sex: F / M SSN: _____-____-_____

Address_____City_____State_____Zip Code _____

Phone: (home/cell)_____(work)_____E-mail:_____

Employer: _____ Phone: ( ) _____

Pharmacy of Choice: _____ Location: _____

Height: _____ Weight: _____

Responsible Party: _____Relationship: _____

GENERAL INFORMATION:

•How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Next of Kin or other to reach in an emergency: _____

Relationship _____ Phone/Cell_____

•Is it okay to leave messages regarding your care on your answering machine o Yes o No

HEALTH HISTORY:

• Are you currently under the active care of another physician? o Yes o No

•Name(s):_____

•If no, when and where did you last receive medical or health care? _____

•Do you see another health care professional on a regular basis (Massage, Therapist, Chiropractor, etc.)? o Yes o No
If so, which type?_____

ALLERGIES: Are you hyper sensitive or allergic
drugs?_____
foods?_____
environmentals?_____
chemicals?_____

Childhood Illnesses

Scarlet fever_____ Diphtheria_____ Rheumatic fever_____ Measles_____ German measles_____ Mumps_____
_____

Please list any **hospitalizations, surgeries or serious injuries** you have had with dates and the reason/illness/injury:
_____

_____

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Please list any **X-rays, CAT scans, MRI's, Ultrasounds** or other diagnostic studies you have had:

_____

_____

Current Medications
Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking.

1) _____ 6) _____
2)_____ 7) _____
3)_____ 8) _____
4)_____ 9) _____

List your most important CURRENT health problems in order of importance:

1)_____ 6) _____
2)_____ 7) _____
3)_____ 8) _____
4)_____ 9) _____

FAMILY HISTORY

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal G.parents	Paternal G.parents
Age if living:							
Age at death:							
Cause of death:							
Cancer							
Depression							
Diabetes							
Heart Disease							
High blood pressure							
Stroke							
Epilepsy							
Mental Illness							
Asthma							
Kidney Disease							
Glaucoma							
Tuberculosis							
Endocrine Disease							
Multiple Sclerosis							
Autoimmune disease							
Neurological Disease							
Other, please list							

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PERSONAL HEALTH HABITS - Please circle if applies to you:

YES / PAST **Smoker** • Smoked for ____ years •Amount per day_____cigarettes/packs •Year/age stopped_____
YES / PAST **Alcohol** • Type_____ • Frequency_____
YES / PAST **Recreational Drugs** • Type_____ • Frequency_____
YES / PAST **Coffee** • Cups per day_____ • Water quantity per day_____
YES / PAST **Regular Exercise** • Type_____ • Frequency_____
YES / PAST **Sleep:Uninterrupted through the night**?_____• How many hours? _____Take naps**?** _____
YES / PAST **History of eating disorder?** _____ •Happy with current diet?_____
How many hours of TV/week?_____ **• How many hours reading/week?** _____

1. **Why did you to come to this clinic?**

2. **What are your 3 top goals regarding your health?**

   1.) _____

   2.) _____

   3.) _____

3. **What expectations do you have of me personally as your physician?**

4. **What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?**

5. **What behaviors do you engage in that you feel sabotage your health? What obstacles do you for see that may hinder your ability to adhere to the treatment protocols we will be discussing?**

6. **How committed are you to making changes that will help you achieve your optimal health? (Please circle only one number. 1 is the least committed and 10 is very committed)**

1 2 3 4 5 6 7 8 9 10

Congratulations on choosing to take charge of your health
Dr. Liz Cavin looks forward to helping you attain your health goals