



**Flower City Naturopathy**

95 Allens Creek Road  
Building 1, Suite 104  
Rochester, NY 14618  
585-322-4695

drbatek@flowercitynaturopathy.com  
[www.flowercitynaturopathy.com](http://www.flowercitynaturopathy.com)

**New Client Profile**

Please answer all questions honestly and with the intent of providing as thorough a picture as possible of your health history. Successful health care and preventative medicine are best achieved when there is open communication.

Today's date: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

What is the best way to contact you? \_\_\_\_\_

How did you find out about our clinic? \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Health Care Provider(s):

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List your major health concerns in order of importance:

1. \_\_\_\_\_ Since when? \_\_\_\_\_
2. \_\_\_\_\_ Since when? \_\_\_\_\_
3. \_\_\_\_\_ Since when? \_\_\_\_\_
4. \_\_\_\_\_ Since when? \_\_\_\_\_
5. \_\_\_\_\_ Since when? \_\_\_\_\_
6. \_\_\_\_\_ Since when? \_\_\_\_\_

What goals do you have for your visit today?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS: List all the drugs (prescription and non-prescription pharmaceuticals)

1. \_\_\_\_\_ Dose: \_\_\_\_\_ Since when? \_\_\_\_\_
2. \_\_\_\_\_ Dose: \_\_\_\_\_ Since when? \_\_\_\_\_
3. \_\_\_\_\_ Dose: \_\_\_\_\_ Since when? \_\_\_\_\_
4. \_\_\_\_\_ Dose: \_\_\_\_\_ Since when? \_\_\_\_\_
5. \_\_\_\_\_ Dose: \_\_\_\_\_ Since when? \_\_\_\_\_

ALLERGIES: Are you sensitive/allergic to any drugs, foods, chemicals, animals, environmental substances? Yes No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

What happens when you have an "allergy attack"? \_\_\_\_\_

What types of allergy testing have you had?: \_\_\_\_\_

**CURRENT SUPPLEMENTS:**

List all vitamins, minerals, herbs, homeopathics, with dosages and when you began taking them:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**PAST MEDICAL HISTORY**

Significant Illnesses or physical traumas: Please describe: \_\_\_\_\_

Hospitalizations or outpatient procedures or special diagnostic studies:

Please describe: \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_ Results: \_\_\_\_\_

Date of last blood work? \_\_\_\_\_ Results: \_\_\_\_\_

**LIFESTYLE:**

Are you currently (please circle):

Single      Married      Partnership      Separated      Divorced      Widowed

Please circle any of the following substances that you use currently or used in the past:

Tobacco      Coffee/black tea/cola      Alcohol      Recreational drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: \_\_\_\_\_

Do you exercise regularly? Yes No What type? \_\_\_\_\_

How long? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins?

No Yes, please explain \_\_\_\_\_

**FAMILY HISTORY:** Please provide ages and past and present health issues for:

Maternal Grandmother \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

Mother \_\_\_\_\_

Father \_\_\_\_\_

Your Sisters \_\_\_\_\_

Your Brothers \_\_\_\_\_

Children's ages and health issues: \_\_\_\_\_

Is there anything else you'd like to share that is not specifically asked about on this form?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_