Dr. Nadine Cyr N.D.

Name:_____ Age: _____Date of Birth:_____

Address:_____

(Street) (City) (Postal Code)

Occupation:_____ Employer:_____

Home Phone:_____ Work: _____

e-mail:_____ Cell: _____

Marital Status: S M D W Sep Referred by: _____

Health Concerns in Order of Importance to You

1) _____ since: _____ prior treatment: _____
2) _____ since: _____ prior treatment: _____
3) _____ since: _____ prior treatment: _____
4) _____ since: _____ prior treatment: _____

Which of the Following Do You Currently Experience or Have Experienced in the Past

__ Sinus Problems
__ Breathing Difficulties
__ Frequent Colds
__ Hayfever
__ Allergies
__ Asthma
__ Cough
__ Bronchitis
__ Pneumonia
__ Strep Throat
__ Alcoholism
__ Anemia
__ Mononucleosis
__ Vision Problems
__ Eye Irritation
__ Diabetes
__ Gout
__ Cancer: _____

__ Hyperactivity
__ Learning Disability
__ Headache
__ Nervousness/Anxiety
__ Depression
__ Insomnia
__ Fatigue (am or pm)
__ Dizziness
__ Fainting
__ Seizures
__ Sexual Abuse
__ Chronic Fatigue
__ Chronic Headaches
__ Migraines
__ Spinal Injury
__ Arthritis
__ Thyroid Disorders

__ Weakness
__ Bed Wetting
__ Painful Urination
__ Frequent Urination
__ Chronic UTI's
__ Incontinence
__ Kidney Stones
__ Cold Sores
__ Shingles
__ Herpes
__ Hives/Skin rashes
__ Acne
__ Eczema
__ Dry Skin
__ Psoriasis
__ Varicose Veins
__ Poor Circulation

__ Chronic Constipation
__ Diarrhea
__ IBS
__ Crohn's / Colitis
__ Parasites
__ Gall Stones
__ Heartburn / Ulcer
__ Belching / Gas
__ Nausea / Vomiting
__ Hemorrhoids
__ High Blood Pressure
__ Pain over Heart
__ Palpitation
__ Shortness of Breath
__ Stroke
__ Swelling Ankles
__ Low Blood Pressure

Men:__ Prostate Problems __ Impotency __ Loss of Sexual Desire __ Low Sperm Count
Women:__ Painful Menstruation __ Irregular Menstruation __ Tender Breasts __Loss of Sexual Desire __ Fibroids ___Mood Changes __ Hot Flashes __ PCO's __ Miscarriage __ Infertility __ # of Pregnancies

Family Health History

Please indicate if any of your immediate relatives now have or have had in the past any of the following conditions? (please note their relationship to you, e.g. mother, father, brother, sister, daughter, etc.)

__ Diabetes _____
__ Heart Disease _____
__ Epilepsy _____
__ Mental Disorder _____
__ Alcoholism _____
__ Anxiety _____
__ Thyroid Disorders _____
__ Fibromyalgia _____
__ Cancer _____
__ Allergies _____
__ Asthma _____
__ Genetic Defect _____
__ Depression _____
__ Multiple Sclerosis _____
__ Ulcerative Colitis/ Crohn's _____
__ Osteoporosis _____

Past Injuries

1) _____ when: _____
2) _____ when: _____
3) _____ when: _____

Past Surgeries

1) _____ when: _____
2) _____ when: _____
3) _____ when: _____

List of supplements or special diets you are now using: _____
_____
_____

List of medications you are currently taking: _____
_____
_____

List of medications have used in the past: _____
_____
_____

Prolonged Antibiotic Use? _____ For which condition(s)? _____
Do you exercise regularly? _____ Type and duration? _____
Do you smoke? Yes _____ No _____
If yes, how many per day: Cigarettes _____ Marijuana _____ Cigars _____
Number of cups daily of:
Coffee _____ Decaf Coffee _____ Regular Tea _____ Juice _____ Soda/Pop _____
Do you drink alcohol beverages? Yes _____ No _____ Type _____
How many drinks per week? _____

Are you regularly exposed to or handle chemicals, heavy metals, solvents, animal products? _____