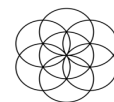


Dr. Nadine Cyr N.D.



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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Weakness | <input type="checkbox"/> Chronic Constipation |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Headache | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Nervousness/Anxiety | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Crohn's / Colitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic UTI's | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Gall Stones |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Fatigue (am or pm) | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Heartburn / Ulcer |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Belching / Gas |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Shingles | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Seizures | <input type="checkbox"/> Herpes | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Hives/Skin rashes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Acne | <input type="checkbox"/> Pain over Heart |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Eczema | <input type="checkbox"/> Palpitation |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Eye Irritation | <input type="checkbox"/> Spinal Injury | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Swelling Ankles |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Cancer: _____ | | | |

- 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.)

<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Allergies _____
<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Mental Disorder _____	<input type="checkbox"/> Genetic Defect _____
<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Anxiety _____	<input type="checkbox"/> Multiple Sclerosis _____
<input type="checkbox"/> Thyroid Disorders _____	<input type="checkbox"/> Ulcerative Colitis/ Crohn's _____
<input type="checkbox"/> Fibromyalgia _____	<input type="checkbox"/> 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? _____