NEW CLIENT EVALUATION

KALO CLINIC NATURAL HEALTH AND HEALING CENTER

Today's Date: ______________________ Referred by: ____________________________________

Name: _________________________________ M ❑ F ❑ Birthdate ____/_____/____ Age ______

Mailing Address: ____

City: ___________________ State: ______________ Zip: _________ Occupation: _______________

Daytime phone: ______________________________ Evening phone: ________________________

Email: ____

1. Complaints Please tell us the main reason why you are here ___________________________

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2. Secondary Complaints Please let us know any other health concerns that you have

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3. Previous Treatment for these Complaints ____

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____
____

4. Major Illnesses Please list any major illnesses and approximate dates __________________

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____

5. Injuries Please list any accidents or injuries, and approximate dates ___________________

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____
____

LAST NAME	FIRST	MIDDLE	Date of Birth	Age	M/F

Primary Care Doctor	Office Number	Last Physical Exam

Height	Weight	*For Weight Loss Patients:*	*Goal Weight*	Lowest Adult Weight

Main Reason for Visit	REFERRED BY

MEDICAL & FAMILY HISTORY	Self	Family		Self	Family		Self	Family
Seizures			Asthma			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder disease/stones		
Loss of Consciousness			Pulmonary Hypertension			Ulcers		
Stroke			Shortness or Breath			Colitis		
Glaucoma			Irregular heart rhythm			Constipation		
Thyroid Disorder			Heart Attack or Angina			Arthritis		
Obesity/Overweight			Palpitations			Gout		
Diabetes Mellitus (DM)			Heart Valve disorder			Osteopenia or Osteoporosis		
High Blood Sugar			Heart Failure (CHF)			Kidney Disease or stones		
Abnormal Cholesterol			High Blood Pressure			Alcohol Abuse		
Insomnia			Rheumatic Fever			Drug Abuse		
Dementia			Tuberculosis			Depression or Anxiety		
			HIV			Eating Disorder		
Other			Cancer (type:)			Other Psychiatric Illness		

DOCTOR NOTES:

SURGERIES & HOSPITILIZATIONS

Reason/Diagnosis	Year

SPECIALISTS (If any)

PRESCRIPTION MEDICATIONS

Medication Name	Dose & Frequency	Approx. Start Date	Reason for use

SUPPLEMENTS & OVER-THE-COUNTER MEDICATIONS

Supplement/Medication Name	Dose & Frequency	Approx. Start Date	Reason for Use

SCREENING

TEST	Last date done	Results (-) *or state findings*
Blood Sugar, Cholesterol		
Colonoscopy		
PAP Smear (women)		
Mammogram (women)		
Prostate exam (men)		
Cardiac test (EKG, echo, stress, etc)		
Transvaginal Ultrasound		

FEMALE patients: Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Sleep disorder				
Anxiety/nervousness				
Irritability				
Depression/emotional swings				
Food cravings				
Hot flashes				
Night sweats				
Vaginal Dryness				
Urine Leakage				
Dry skin/ wrinkles				
Dry Hair				
Fatigue				
Memory Loss				
Concentration loss				
Hair loss				
Concentration loss				
Hair Loss				
Loss of Libido/ orgasm				
Muscle weakness/loss				
Muscle and Joint pain				
Loss of pubic hair				

MALE patients: Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Dry Skin				
Dry Hair				
Sleep disorder				
Fatigue				
Memory loss				
Concentration loss				
Anxiety/nervousness				
Irritability				
Depression				
Loss of libido/orgasm				
Difficulty maintaining erection				
Difficulty achieving erection				
Premature ejaculation				
Muscle weakness				
Muscle Loss				
Muscle and Joint pain				

Loss of masculinity/confidence/aggressiveness				

OB/GYN HISTORY (Female patients)

Last Menstrual Period:	Age at first onset of period:
If still menstruating: cycle ________days	Circle if (+): Heavy periods, irregularity, spotting or pain
Are you pregnant: NO YES	Are you breastfeeding: NO YES
Number of pregnancies: C-section/Vaginal Birth	Abortions________ Miscarriages_____
History of sexual abuse	

PERSONAL AND SOCIAL HISTORY

Occupation:	Stress Level (1-10):
Marital Status: # Living Children:	Do you feel safe in your relationship:
Use of alcohol **NO** **YES** If YES, what kind:	How many drinks per week:
Tobacco: **No** **YES** If YES, number of years total ____________	Past-use---quit date: ___________________
Recreational or street drug use: **NO** **YES** If YES, have you ever taken street drugs with a needle: NO YES	
Sexually active **NO** **YES**	*Contraception* Current method:___________________ Past method: ______________________
Hobbies/Interests	

REVIEW OF SYSTEMS

Please check YES to any symptom that you experience. For any YES answer please provide a brief description

	YES	If YES, **list doctor seen**, describe condition and how long
Fever/chills		
Excess fatigue		
Weight loss/gain		
Enlarged lymph nodes		
Frequent bruising		
Blurry vision		
Ringing in ears		
Hearing difficulty		
Mouth sores		
Sinus problems		
Cardiovascular:		
Chest pain at rest or		

exercise		
Cold hands/cold feet		
Swelling of legs		

Gastrointestinal	**YES**	
Constipation		**# bowel movement/day**
Diarrhea		
Bloating		
Excessive belching		
Gas/acidity		
Blood in stool		
Thirst: Lack of/too much		**# glasses of fluid/day**
Genitourinary		
Pain on urination		
Cloudy/blood urination		
Urinating too many time		# of time per day
Difficulty urinating		
Loss of Urine		

Musculoskeletal: ***If YES to any of following questions, please grade pain 1-10.***

Did you see a chiropractor?	**YES**	
Any regular body treatment/massage?		
Back Pain		
Neck Pain		
Shoulder Pain		
Arm Pain		
Hip Pain		
Knee Pain		
Other Pain		
Muscle point tenderness (please describe)		

Skin	**YES**	
Acne		
Dry Skin		
Oily Skin		
Loss of collagen/Firmness		
Wrinkles		
Pigmentation/Scarring		
History of skin cancer?		
Do you wear sunblock?		

Emotional	**YES**	
Do you see a counselor or psychiatrist?		
Depression		
Anxiety		
Stress		
Previous or current thoughts of suicide?		

I have answered the above to the best of my abilities.

Patient Signature: ____

Nutrition Evaluation

Vegetable intake (please circle): <10%   20-40%   41-60%   >60%
Number of meals per day:
Snacks per day: What snacks and when?
Food Allergies
Food Dislikes
Foods(s) you crave
Do you awaken hungry during the night?   If yes, when?
Behavior style (*check only one:)* ____Always calm and easygoing ____Usually calm and easygoing ____Sometimes calm with frequent impatience ____Seldom calm and persistently driving for advancement ____Never calm and have overwhelming ambition ____Hard-driving and can never relax

	NO	YES		NO	YES	If not you, WHOM?
Partner or spouse overweight?			I plan my meals			
By how much?			I cook my meals			
I eat out daily			I shop for food.			
I eat out ______times/week			I use shopping list for grocery			

I eat "fast foods" daily			I use sugar substitute			
I eat "fast foods"____ times/week			I use butter.			
I drink soda drinks.			I use margarine.			
I eat when I'm stressed.			I drink coffee or tea. How many cups?			
I am currently stressed.						
I skip meals.						

Typical Breakfast

____
____
____
____
____
____

Time eaten: _________
Where: ______________
With Whom:_________

Typical Lunch

____
____
____
____
____
____

Time eaten: _________
Where: ______________
With Whom:_________

Typical Dinner

____
____
____
____
____
____

Time eaten: _________
Where: ______________
With Whom:_________

Activity Level (**check only one)**

_____ Inactive: no regular physical activity with a sit-down job.
_____ Light activity: no organized physical activity during leisure time.
_____ Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____ Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session at least 4 times per week.

Please describe your general health goals and improvements you wish to make:
____
____
____

Additional NOTES:

Patient Signature: ____