Name: ___________________________ Age _____ Email:_________________

Phone # :_______ ______________ Referred by: ________________________ _______

Please read and sign: I am here to learn about nutrition and am seeking information about a wholesome diet, food supplements, herbs and natural therapies. I understand that Pat Block is a registered *Doctor of Natural Medicine* **not a licensed medical doctor**. I am not seeking a medical diagnosis, treatment or prescription for any illness. If I have a medical problem I will see my medical doctor. I have read and understand the MUST READ post on Pat's website.

Date ____________________ Signed ____.___

_ _

Blood Type ________ (This is helpful if you can find this info)

The doctor said I have(had)...____

I am taking these drugs/ OTCs regularly/prn ____

In the blanks below, please assign intensity to the following symptoms from **10** (worst) to **1** **Leave Blank** if it is never a problem
Example: **10.** Major problem - one of the main reasons I'm here **1.** Slight problem - occurs but doesn't bother me, I ignore it
(elaborate where lines are provided)

___Abdominal pain __upper, __lower	___Food sits on stomach after eating	___Muscle or leg cramps ___at night, _____ with inactivity____with exercise
___Acid indigestion/ heartburn	___Foot / heel pain	___ Night sweats
___ Addictions to ______________	___Frequent thirst	___Numbness, where?_____________
___Allergies, food _______________	___Hair loss	___Physical trauma as __child, __adult
___Allergies, respiratory __________	___Headaches or migraines	___PMS
___Anemia	___Heart beats irregular	___Prostate problems
___Anger, excessive	___Hemorrhoids	___Restless dreams or nightmares
___Anxiety, nervousness, panic attacks	___High blood pressure_____/______	___Ringing in the ears
___Appetite, ___poor,___excessive	___High cholesterol _________	___Sinusitis or sinus congestion
___Back pain __upper, __mid,__lower	___Hot flashes ___ at night only	___Skin (acne, rashes, lesions etc)
___Bad breath or body odor	___Hypoglycemia	___Sleep problems: ___falling asleep; __staying asleep; __awake tired
___Bruise easily	___Impotence (males only)	___Shortness of breath
___Burning feet at night	___Incontinence	___Snoring / sleep apnea
___Chest pain	___Infections often, where?________	___Stiffness ____with inactivity
___Cold hands / nose / feet / skin	___Infertility	___Stomachache, when?__________
___Congested lungs/ wheezing	___Intestinal gas, bloating, belching	___Stress
___Constipation or dry stools	___Irritable often	___Surgeries ____________________ ________________________________
___Coughing, chronic	___Itching, skin, where?________	___Sweaty hands / feet
___Cravings for ______________	___Itchy nose or ears	___Swollen lymph glands
___Depression	___Joint pain or gout	___Teeth grinding
___Diarrhea/ loose stool	___Keyed up - cannot calm down	___Varicose veins
___Difficulty swallowing	___Loss of sexual desire	___Viral (_ColdSores, _Genital,_Shingles)
___Dizziness or light-headedness	___Loss of smell / taste	___Water retention, swelling or edema
___Drowsy often, when?________	___Loss of hearing	___Watery eyes, runny nose
___Dry skin	___Lump in throat sensation	___Weakness, where? ______________
___Dry __eyes, __nose, __mouth	___Menstrual disorders__________	___Wounds that won't heal
___Emotional trauma as _child, _adult	___Mood swings	___Yawns often
___ Eye bags / dark circles	___Mucus excess / constant drainage	___Yeast infections
___ Fatigue, chronic	___Nausea	
___ Fear, excessive	___Muddled thinking, confusion	
___ Fever often	___Muscle tension / trigger points	

Return both sheets
by fax (757) 867-8241

Check if you have a family history of __heart disease, __cancer, or __diabetes

I really do read these. They are important to me. So please write clearly – or dictate to someone who does. Thanks. Pat

Symptom / Diagnosis / Complaint / Problem	How long have you had this?	What do you think it is the result of…or related to… (not what the doc said)	What are some things that have helped you with this?

Please check one of the following...
Option 1. ___ I would like you to mail me the supplements and send me a bill for them and the consultation. (Since some supplements are only available through a practitioner, we may need to do this.)

Option 2. ___ I will order the supplements myself (if I can) on my NSP account. Please send me a bill for the consultation.

Option 3. ___ There is a store near me where I may be able to get the herbs. Please send me a bill for the consultation.

Other preferences_____

Your address:

_____

_____

_____