

Ann B. Davis, ND
830-331-9096
annbdavisnd@hotmail.com

Name _____

Responsible Party (if a minor) _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Email _____ Cell Phone _____

Birthdate _____ Age _____ Sex: M F Height _____ Weight _____

Business/Employer _____ Type of Work _____

Check: Married _____ Single _____ Widowed _____ Separated _____ Divorced _____

No. of children _____ Referred to this office by _____

NOTICE OF UNDERSTANDING AND AGREEMENT

I attest to the following:

1. The consulting services performed by Ann B. Davis are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease) so that I will have greater self-awareness and can use a self-care program for daily living.
2. I understand that as a Naturopath she recommends, talks about, and/or sells foods, nutritional supplements, vitamins, minerals, herbs and other nutrients as foods for special dietary use only as they pertain to the whole body idea of nutrition, and not in any specific ailment or condition.
3. I fully understand that Ann B. Davis is a Naturopath and is not a medical doctor, and I am not consulting for medical, diagnostic or treatment procedures.
4. I am here, on this and any subsequent visits, solely and on my own behalf and not as an agent for any federal, state or local agency on a mission of entrapment or investigation.
5. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines for the treatment of disease, or any act that is the practice of medicine in the state for which a license is required.

Signature of Responsible Person: _____

Date: _____

HEALTH PROFILE

Please answer the following questions about your diet. Fill in the blanks appropriately or circle the correct response.

Indicate what your typical daily food intake looks like. Include breakfast, lunch, dinner, between meal snacks, time of day, and types of food (also noting fresh, frozen or canned) and amounts.

Do you eat sugar and/or artificial sweeteners? Yes/No How frequently? _____

How often do you eat junk food or fast food? _____

How many glasses of water do you drink daily? _____

How often do you consume alcohol or mind-altering substances? _____

Do you smoke? Yes/No How many cigarettes a day? _____

Do you take any medications? Yes/No Please list them:

Do you take any nutritional supplements? Yes/No Please list them?

How often do you move your bowels? _____

How frequently do you exercise, what type, and for what amount of time?

Have you ever taken birth control pills or a series of antibiotics? _____

Do you have any dental work in your mouth? Please describe briefly (i.e. fillings, crowns, a bridge, etc.) _____

MEDICAL HISTORY

Do you suffer from any of the following physical conditions? Please check.

___ Allergies

___ Herpes

___ Anxiety

___ High blood pressure

___ Arthritis

___ High cholesterol

___ Bladder infections

___ Hypoglycemia

___ Chronic pain/where?

___ Muscle spasms/cramps

___ Colitis

___ Overweight

___ Depression

___ Premenstrual syndrome

___ Diabetes

___ Prostate trouble

___ Digestive disturbances

___ Sexual disability

___ Diverticulosis

___ Sleeplessness

___ Dizziness

___ Thyroid imbalance

___ Eliminary problems

___ Yeast infections

___ Fatigue

___ Ulcers

___ Hardening of the arteries

___ Other (please list)

___ Heart disease

___ Hemorrhoids

Any surgeries?

What is your family history of disease? Include grandparents, parents and siblings.
