BRANNICK CLINIC
of Natural Medicine
WHOLE HEALTH PRIMARY CARE & WELLNESS

1013 31st St., LaGrange Park, IL 60526 708.447.2468 • 1650 E. Main St., St. Charles, IL 60174 630.444.0066 • www.brannickclinic.com

PATIENT PROFILE

DATE: ___________

Last Name _________________________________ First Name ____

S.S.N: ___________________________________ Birthdate _________________ Sex __________________

Address __________________________________ City / ST / Zip ____

Email ____________________________________ Phone: (H) ___________________(C) ________________

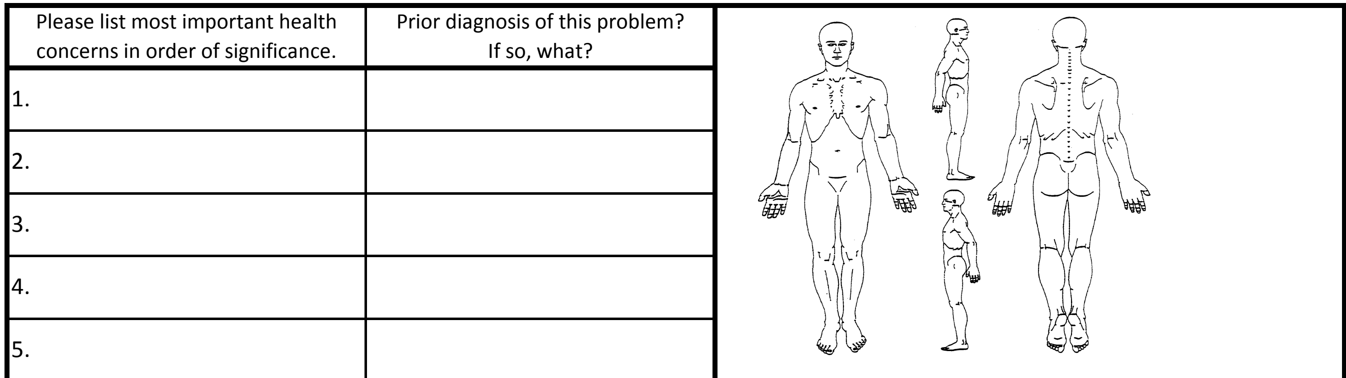
Martial Status: Single Married Reminders: Text Email Phone Call

Employer: _____________________________ Employer Phone: ____

Note to our patients: Please complete this 2-sided questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Indicate painful or distressed areas:



Please list most important health concerns in order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit at the clinic today? ____

____

Have you ever consulted a Naturopathic physician, and acupuncturist, a nutritionist, a chiropractor or a counselor before?

PLEASE CIRCLE ALL THAT APPLY

Do you have any questions about our clinic or the care that you've chosen today? ______________________________________

____

Please list prescription medications you are currently taking, with dosages (if possible):

1. ___________________________ 2. __________________________ 3. ___________________________________

4. ___________________________ 5. __________________________ 6. ___________________________________

Please list vitamins, minerals, herbs, homeopathic remedies you are currently taking, with dosages (if possible):

1. ___________________________ 2. __________________________ 3. ___________________________________

4. ___________________________ 5. __________________________ 6. ___________________________________

Please list any severe or life-threatening allergies: ____

Explain: ____

Personal Habits

Please circle any of the following substances that you use regularly: **Tobacco** **Coffee/black tea/soda** **Alcohol** **Recreational drugs**

Do you follow any particular diet regimens or restrictions? If yes, please describe: ____

____

Do you exercise regularly? **YES** or **NO** (circle one) What type? ____

How long? ________________________________ How often? ____

Past Medical History

Hospitalizations: ____

____

Serious Illnesses and injuries: ____

____

Date of last physical / annual exam: __________________________ Date of last blood tests: _____________

Personal and Family History

Please check the "YES" box next to each condition that applies to you or one of your family members. Please note whether the condition applied to you or your family member in the past by denoting a "P for past or "C" for current. Indicate the relationship or the word "Self" in the relationship column.

CONDITION	YES	RELATION	PAST (P) CURRENT (C)	CONDITION	YES	RELATION	PAST (P) CURRENT (C)
Alcoholism / Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History

Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list ages: ____________________

How did you hear of us? ____