aVerdure

Initial Consultation

South Hills PT Clinic
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Eugene, OR 97405
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www.averdure.com

All of your personal information will remain strictly confidential!

Date: _____

Name: _____

Cell phone: _____

Email: _____Home phone: _____

Address: _____

Date of Birth: _____

Age: _____ Gender: _____ Height: _____ Current weight: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ How many hours do you work per week? _____

Relationship status: _____ Children? _____

Blood Type (if known) _____ Referred by: _____

Hobbies/Activities: _____

What are your health concerns? _____

_____

_____

What would you like to accomplish from this consultation? _____

_____

Do you like to cook? _____ Do you eat 3 meals/day? _____

What percentage of your food is home cooked? _____

How often do you eat out? _____

What are the three worst foods you eat each week? _____

_____

What are the three healthiest foods you eat each week? _____

_____

What were your eating habits like as a child? (List types of foods) _____

_____

Do you drink caffeinated drinks? _____ How much and how often?_____

Do you drink soda (diet or regular)? ___ How much and how often? _____

Do you crave sugar? _____ Do you crave salt? _____

Do you drink alcohol? _____ How much & how often? _____

Do you wake at night? _____ How many times per night? _____

If, so what time do you wake up? _____ What time do you go to bed? _____

Do you feel tired, bloated, and/or gassy after meals? _____

Do you experience constipation or diarrhea often? _____

Are you a vegetarian or vegan? _____

Have you been exposed to toxic substances at work or home?

_____

Do you have any known allergies, including medications? _____

_____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts: Are you on medications? If so, for what?

_____

_____

_____

Are you currently under a practitioner's care for a specific health issue? _____

If so, what treatments are you undergoing? _____

_____

Please list any surgeries, accidents, injuries or childhood diseases you have had along with the type and approximate date: _____

_____

WOMEN ONLY

Age of your first period: _____ Are your periods regular? _____

How frequent? _____ How many days in your flow? _____

Do you experience PMS? _____ Is it mild or severe? _____

Are you peri-menopausal? _____ When was your last period? _____

List your symptoms of peri/menopause _____

_____

How many children have you delivered and how were they born (vaginally or by cesarean)?

_____

Were there complications associated with those births? _____

Please explain _____

_____

Did you receive antibiotics during labor? _____

Have our every had a miscarriage? _____

MALE ONLY

Approximate age of onset of puberty _____ Do you feel your libido is adequate? Y N

Do you have any difficulty and/or pain with urination? Y N Diminished volume or flow? Y N

Do you enjoy daily activities? Y N

Do you notice feeling more agitate/irritable than previously? _____

Is there any other information you feel important to include?

_____

_____

_____