Rogue Natural Medicine Client Form

Personal Information

Date of Birth:_____ Age:_____ Today's Date:_____
First Name:_____Middle:_____Last Name:_____
Preferred Name:_____ Gender: F / M
Address _____City:_____State:_____Zip:_____

Live with: Alone_____ Spouse_____ Partner _____ Family_____ Housemate _____ Other _____
Spouse's Name:_____ Number of children:_____
Your occupation: _____ Work hours per week:_____

Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____

How did you hear about us?_____

What are your top three long-term health goals in working with Dr. Kunkel (in order of importance)?

1)
2)
3)

Circle your present level of motivation for addressing the underlying causes of your health challenges on a scale of 1-10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe contribute to and **support your health**? _____

What behaviors or lifestyle habits do you currently engage in regularly that you believe detract from or **hinder your health**? _____

Do you have or foresee any **obstacles** that may hinder your ability to make lifestyle changes or follow intensive health protocols? _____

History

What are your main health challenges (list them in order of importance)? What are you doing for them? Effective? (Y/N)

(1
(2
(3
(4
(5

Any health complaints that run in the family? Please List: _____

Please list any **serious conditions, illnesses, injuries, or hospitalizations**.

Date or Year	Surgery, Illness, Injury, etc.	Outcome

Do you have any **allergies/sensitivities** (food, medicines, environmental, etc)? What is your **reaction**?

Allergy	Describe your Reaction

Please list all **current prescription medications**, dose, and what it is being used for:

Medication	Dose	For what condition?

Please list all **over-the-counter medications, vitamins, herbs, homeopathics, etc.** and why they are being used:

Product	Dose	For what purpose?

Did you receive vaccines as a child? Y / N How many?:_____
Any reactions to the vaccine(s)? Y / N Explain:_____
Have you taken antibiotics in the last 5 years? Y / N If yes, how many times?_____
Were you given antibiotics as a child? Y / N How often?_____
Do you have root canals? Y / N How many?_____ When were they placed?_____
Do you know your blood type? A / B / AB / O / Don't know

Female (if applicable)
Are you currently (circle): pre-menopausal perimenopausal post-menopausal Age at menopause?_____
Could you be pregnant? Y / N Date of the beginning of your last menses_____
Age at first period:_____ Are your periods regular? Y / N How long is/was your cycle?_____
Symptoms before or during your period? Y / N If yes, what?_____
Do you use birth control? Y / N Method:_____ Since:_____
Number of pregnancies:____ Number of miscarriages:____ Number of abortions:___ Number of live births:___

Which of the following do you currently use? (Y = current, P = past, N = never)

Substance	Y	P	N	Per Day	Type(s)	Duration
Coffee						
Black tea						
Soft drinks						
Artificial sweeteners						
Alcohol						
Tobacco						
Recreational drugs						
Laxatives						
Antacids						
Painkillers/NSAIDs						

Lifestyle:

Current height: ____feet ____in Current weight:_____lbs Desired weight if different:_____lbs
Weight 1 year ago:_____lbs Maximum weight:_____lbs When?:_____
How would you rate your general state of health? (circle one): Poor Fair Average Good Excellent
Please rate your energy level: low 1 2 3 4 5 6 7 8 9 10 high
What time of the day is your energy highest?_____ What time is your energy lowest?_____
Please rate your stress level: low 1 2 3 4 5 6 7 8 9 10 high
List your major stressors: _____
How does your stress manifest?_____
How do you cope with stress?_____
Do you have a strong emotional support network? Y / N Who?_____
Any major traumas (mental/emotional)? Y / N What and when?_____
Hobbies? Y / N Please list:_____
Regular exercise? Y / N Doing what?_____
For how many minutes/hours at a time?_____ How many times per week?_____
How many hours of sleep do you get each night?_____ Do you wake feeling rested? Y / N
Do you wake in the night? Y / N For any particular reason? Y / N At any particular time?_____
Do you enjoy your work? Y / N Spend time outside? Y / N History of abuse? Y / N
Religious/spiritual practices? Y / N Do you take vacations? Y / N
Are you aware of any current or past significant environmental exposure to pollutants/toxins? Y / N
If yes, what were you exposed to? _____ and when?_____

Diet (Please be as honest as possible):

Describe an average breakfast:_____
Describe an average lunch:_____
Describe an average dinner:_____
Do you generally prepare your meals? Y / N If not, who does?_____
Do you snack? Y / N When?_____ What?_____
How much water do you drink per day? (8 oz = 1 cup) _____ Do you use a water filter? Y / N
What is your current diet? (gluten-free, vegetarian, dairy-free, Paleo, none, etc.)_____
How often do you eat out?_____per day or _____per week. Fast food? Y / N
Do you eat on the run or while working? Y / N Do you skip meals? Y / N
What percentage of your fruits/vegetables are organic? 0% 10 20 30 40 50 60 70 80 90 100%
Do you have any food sensitivities or difficulty digesting specific foods? Y / N List:_____
What foods do you crave/are your favorite?_____
What foods repulse you/are your least favorite?_____
Do you feel like you have any unresolved emotional/psychological issues around food/eating? Y / N
How often do you have a bowel movement?_____per day / week (circle which one)

General Overview:
Please circle whether you are experiencing these symptoms currently (C) and/or have ever experienced them in the past (P). If the symptom doesn't apply, don't circle anything.

General:
C / P Weakness
C / P Fatigue
C / P Fever
C / P Chills
C / P Recent weight changes
C / P Fainting

Skin:
C / P Rashes
C / P Nail/hair changes
C / P Acne
C / P Boils
C / P Changes in mole(s)
C / P Color change of skin
C / P Skin cancer
C / P Dry skin
C / P Itching

Head:
C / P Headaches
C / P Injury
C / P Dizziness
C / P Lightheadedness

Eyes:
C / P Recent vision changes
C / P Eye pain
C / P Double or blurry vision
C / P Blind spot(s)
C / P Dry eyes
C / P Sensitivity to the sun
C / P Itching
C / P Redness
C / P Discharge
C / P Floaters
C / P Thinning eyebrows

Ears:
C / P Hearing loss
C / P Sensitive hearing
C / P Ringing
C / P Pain
C / P Infection
C / P Discharge

Nose/Sinus:
C / P Frequent colds
C / P Frequent nose bleeds
C / P Nasal discharge
C / P Nasal/sinus congestion
C / P Stuffiness
C / P Allergies/hayfever
C / P Injury
C / P Loss of smell
C / P Polyps
C / P Difficulty breathing through nose

Mouth/Throat:
C / P Frequent sore throat
C / P Hoarseness
C / P Teeth grinding
C / P Loss of teeth
C / P Gum problems/ bleeding
C / P Mercury fillings
C / P Root canals
C / P Swollen glands
C / P Thyroid problems
C / P Pain/stiffness in neck
C / P Canker sores
C / P Bad breath
C / P Dry tongue/mouth
C / P Loss of taste
C / P Sores/ulcerations
C / P Difficulty swallowing

Respiratory:
C / P Difficulty breathing
C / P Hyperventilation
C / P Pain with breathing
C / P Persistent cough
C / P Persistent infections
C / P Shortness of breath (SOB)
C / P SOB on exertion
C / P SOB while lying down
C / P Spitting up blood
C / P Wheezing
C / P Chronic sputum production
C / P Tuberculosis

Cardiovascular:
C / P Heart problems
C / P High blood pressure
C / P Low blood pressure
C / P Irregular heart beat
C / P Blue lips/nails
C / P Cold hands/feet
C / P Blood clots
C / P Ankle/leg swelling
C / P Fainting
C / P Bruise easily
C / P Bleed easily

Gastrointestinal:
C / P Abdominal pain
C / P Bloating
C / P Belching
C / P Excessive gas
C / P Constipation
C / P Diarrhea
C / P Gallstones
C / P Heartburn/reflux
C / P Indigestion
C / P Nausea
C / P Vomiting
C / P Vomiting blood
C / P Worse after fatty foods
C / P Hemorrhoids
C / P Bloody stools
C / P Ulcers
C / P Mucus in stool
C / P Undigested food in stool
C / P Black, tarry stool
C / P Liver problems
C / P Gallbladder removed
C / P Hernia

Urinary:
C / P Blood in urine
C / P Cloudy urine
C / P Dark urine
C / P Foamy urine
C / P Foul smelling urine
C / P Frequent urination
C / P Difficulty holding urine
C / P Night urination
C / P Painful urination
C / P Reduced urine flow
C / P Urinary hesitancy
C / P Frequent infections
C / P Kidney stones

Musculoskeletal:
C / P Backache
C / P Bone pain
C / P Broken/fractured bones
C / P Osteoporosis
C / P Heel spurs
C / P Joint pain
C / P Joint stiffness
C / P Joint swelling
C / P Muscle cramps/ spasms
C / P Muscle wasting
C / P Sprain joints easily

Neurological:
C / P Involuntary movements
C / P Loss of balance
C / P Loss of coordination
C / P Seizures
C / P Weakness or paralysis
C / P Numbness/loss of sensation
C / P Tingling
C / P Tremors/twitches
C / P Significant memory loss
C / P Trouble concentrating
C / P Nerve pain

Mental/Emotional:
C / P Regularly feeling down
C / P Extreme anger
C / P Excessive irritability
C / P Mood swings
C / P Anxiety/nervousness
C / P Panic attacks
C / P Sexual difficulties
C / P Excessive fears/ phobias
C / P Excessive worry
C / P Drug abuse
C / P Psychiatric care
C / P Psychological counseling

Male Reproductive:
C / P Sexually active
C / P Decreased sex drive
C / P Increased sex drive
C / P Performance problems
C / P Infertility
C / P Prostate problems
C / P Testicular pain
C / P Hernia
C / P Infection
C / P Discharge or sores

Female Reproductive:
C / P Sexually active
C / P Pelvic pain
C / P Pain with intercourse
C / P Decreased sex drive
C / P Increased sex drive
C / P Infertility
C / P Excessive menstrual flow
C / P Absent menstrual flow
C / P Irregular menses
C / P Spotting before/after periods
C / P Vaginal infections/ discharge
C / P Vaginal itching
C / P Vaginal dryness
C / P Ovarian cysts
C / P Cervical infections

Breasts:
C / P Lumps
C / P Pain/tenderness
C / P Nipple discharge
C / P Perform self breast exams
C / P Implants/surgery