

1 World Medicine, Inc.

Uniting Western, Eastern and Holistic Medicines
3110 S. Valley View Blvd. Suite 103, Las Vegas, NV 89102
Tel. (702) 445-7031 Fax. (702) 333-5329

Hours

7:30 am to 5:30 pm M-F
9:00 am to 4:00 pm Saturday

Pt Name: _____
DOB: _____
Mrn: _____

Date completed: _____

Date/Time of Appointment: _____

Primary care provider: _____

Referring provider: _____

Please attach medical records as appropriate.

Concern (Please rank by priority) <i>Example: Headache</i>	Onset <i>June '99</i>	Frequency <i>4 times/week</i>	Severity <i>Mild/Moderate/Severe</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What are your goals for this visit?

Please list any supplements, vitamins or herbs you are taking now.

Brand or Other Name (manufacturer) <i>Example: Siberian ginseng</i>	Reason <i>Energy</i>	Year Started <i>2001</i>	Dosage <i>500 mg twice a day</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Occupation _____

What interests/hobbies do you have?

With whom do you live? (Include roommates, friends, partner, spouse, children, parents, relatives, and pets.)

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pt Name:
DOB:
Mrn:

In what physical activity(ies) do you participate?

What are the major stressors of your life?

Religious affiliations, past and present?

What complementary and alternative therapies have you experienced or explored?

Tobacco?	Never	Smoked from age ____ to ____	_____ packs per day
Alcohol?	Never	Estimated drinks per day _____	
Other drugs?	Never	Type & frequency _____	

Nutrition History

Recall of Dietary Intake

Please list all food and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages, and condiments.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Is this a typical day? If not, why not? Please describe: _____

Are there any types or group of foods you crave or eat a lot? _____

Are there any types or groups of foods you dislike or rarely eat? _____

Pt Name:
DOB:
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What do you drink on a typical day? _____

What type of oil do you cook with? _____

What type of spreads do you add to your foods? _____

How many servings of fruit do you eat/drink each day? _____

Serving = 1 small piece of fruit, 1/2 cup of juice, 1/2 cup canned or chopped fruit, 1/4 cup dried or 1 small piece.

How many servings of vegetables do you consume each day? _____

Serving = 1/2 cup raw or cooked, 1 cup fresh, green leafy vegetables, 1/4 cup dried or 1 small piece.

How would you describe your relationship with food? _____

Completed by: _____ Date: _____

If not patient, relationship to patient: _____

Reviewed by: _____ Date: _____ Time: _____