

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized me to do so. Dr. Diane D. Spindler CNT. PhD. www.mountainholistic.com diane@mountainholistic.com

Mountain Holistic Health – History Form

PO Box 959 Indian Hills CO. 80454 Ph (303) 697-1736 Fax (303) 697-6687

Name (Print) _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Fax _____ Email Address _____

List of Primary Physicians who care for your health:

Name _____ Specialty _____ Location _____

- 1.
- 2.
- 3.
- 4.

Employer: _____ Type of work: _____

Age _____ Height _____ Weight _____ Birth date _____

For what reasons are you seeking this nutrition evaluation? _____

List all Symptoms you are now experiencing:

List below any sickness, disease, and hospitalizations etc. that you can recall since birth:

List all medications you are now taking and the amount of each:

| Name | Dosage | Name | Dosage |
|------|--------|------|--------|
| 1. | | 1. | |
| 2. | | 2. | |
| 3. | | 3. | |

X-rays? Chest Stomach Colon Gallbladder Back
Other

Women Only : Menstrual History

Age of onset ? _____
Regular cycle? Yes ___ No ___
Clots? Yes ___ No ___
Pain or Cramping? Yes ___ No ___
Flow is Heavy ___ Medium ___ Light ___
Abnormal Discharge? Yes ___ No ___
Date of last period _____
Date of last exam _____
Date of last smear _____
Normal? _____
Pregnancies? _____
Any Problems? _____

List all medical conditions you are now being treated for: _____

Any blood relative ever had: Please Circle Who?

| | | |
|---------------------|-----|----|
| Cancer | Yes | No |
| Tuberculosis | Yes | No |
| Diabetes | Yes | No |
| Heart Trouble | Yes | No |
| High Blood Pressure | Yes | No |
| Stroke | Yes | No |
| Mental Disorder | Yes | No |
| Depression | Yes | No |
| Suicide | Yes | No |

Other major illnesses for relatives _____

Personal Care: Circle any of the following you use on a regular basis:

Hair Spray Cologne Perfume Deodorant Antiperspirant Cosmetics Eye Drops
Scented Soaps or Detergents Dryer Fabric Scent Fluoridated Products Ammonia Clorox

Circle any of the following you do on a regular basis: Jogging Running Swim Walk
Bicycle Gardening Yoga Meditation Breathing Exercises Aerobics Weight Lifting
Other: _____

Do you have trouble falling asleep or sleeping through the night? _____

Circle any of the following you feel most affected by : Sunshine Lack of Sunshine
Dampness High Humidity Cold Heat New Moon Full Moon Spring Summer
Fall Winter

Digestion Problems ? _____

| | | |
|--|----|-----|
| Do you have indigestion ½ to 1 hour after meals? | No | Yes |
| Do you have indigestion 3-4 hours after meals? | No | Yes |

What is your drinking water source? Circle

Bottled Reverse Osmosis Distilled Tap Well

Do you smoke or use? Yes or No What? Cigarettes Pipe Cigars Marijuana

How often? _____ Other Drugs? _____

Do you use or drink any of these?

How much/how often/what kind?

Alcohol _____

Coffee _____

Sugar _____

Soft Drinks _____

Do you have any strong cravings for particular foods? _____ What? _____

Are there any food you avoid? _____

Breakfast yesterday was: _____

Lunch yesterday was: _____

Snacks yesterday were: _____

Dinner yesterday was: _____

Anything else I need to know? _____

Patient Informed Consent to Treatment

I, _____, request Dr. Diane D. Spindler to provide me with dietary and/or nutritional recommendations as an aid to the treatment and management of my condition _____.

I am fully aware that these dietary and/or nutritional recommendations are experimental and medically unproven. I am also aware that these recommendations are designed only to supplement traditional methods of treatment and that no guarantee is offered as a cure or outcome from their use in the treatment of my condition.

I agree that, if recommended I shall continue to consult another physician concerning traditional methods of care, which may serve to act as an adjunct to the dietary and/or nutritional recommendations presented to me.

I hereby certify that the content and significance of this form is fully understood by me and I choose to have Dr. Spindler consult with me on my health needs.

Client's Signature _____

Date _____

Consultant's Affirmation

I certify that I have explained the contents of this document to the client and have answered all questions at this point concerning it and the recommendations made. To the best of my knowledge, I feel the client has been adequately informed and has consented to the dietary and/or nutritional recommendations presented.

Dr. Diane D. Spindler
