Covenant Natural Health Care, LLC
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New Client Introduction Form

Name: _____ Date: _____

1. Chief Concerns:

2. Dietary Intake for 2 days before appointment (all foods and liquids):

Breakfast	Breakfast:
Snacks:	Snacks:
Lunch:	Lunch:
Snacks:	Snacks:
Dinner:	Dinner:
Snacks:	Snacks:
Drinks:	Drinks:

Prescription, OTC, Supplement
And other products history

Name_____ Date _____

Please list any prescription medications you are currently taking or have taken in the last year.
Use other side if more room is needed. **Please print clearly**.

Medication/Dosage	Diagnosis
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any (OTC) over-the-counter medications you are currently taking or have taken in the last year.

Product	Symptoms	Quantity & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the past year.

Product	Symptoms	Quantity & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check the items you use and indicate the amount and frequency. (Example: 1 liter coke/day)

☐ Coffee _____	☐ Power Drinks _____	☐ Ice Cream _____
☐ Soft drinks _____	☐ Laxatives_____	☐ Alcohol _____
☐ Diet Soft Drinks _____	☐ Artificial Sweetener _____	☐ Cigarettes _____
☐ Tea sweet/unsweet_____	☐ Antacids _____	☐ Other Tobacco _____
☐ Juice _____	☐ Candy _____	☐ Breakfast Bars_____

How many desserts do you have in an average week? _____