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?

			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

____