Brian Casteels, ND
1-800-868-5508
casteelsnd@gmail.com
www.drbriancasteels.com

Name _____

Date _____

Date of birth _____ (M/D/Y) **Sex M F**

Address_____
_____
_____
_____
_____

Email Address_____

Home Telephone #_____

Work Telephone #_____

Can I leave messages relating to your visits? Y / N

Which Phone Number? _____

Emergency Contact_____

Name_____

Phone #_____ **Relation**_____

How did you hear about the clinic:

Newspaper ___ **Mailer** ___ **Referral** _____

Radio___ **Other**_____

Other health care providers you are seeing: 1. _____ _____ _____ _____ (_____)_____	2._____ ___ _____ _____ _____ _____ (_____)_____ ___	3. _____ __ _____ _____ _____ _____ (_____)_____

What are your health concerns, in order of importance to you:

1._____
_____

2._____
_____

3._____
_____

4._____
_____

5._____
_____

If you are female are you currently pregnant? Yes No (Please circle one)

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

_____
_____
_____
_____
_____
_____

Do you have any allergies (medicines, environmental, etc.)?

_____
_____
_____
_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

Please list past prescription medications.

_____
_____
_____
_____

How many times have you been treated with antibiotics?

_____

Do you frequently use any of the following? (circle)
Aspirin / Laxatives / Antacids / Diet pills / Birth control: pills / implants / injections
Alcohol—how much/day or week
_____
Tobacco—form and amount/day
_____
Caffeine—form and amount/day_____
Recreational drugs—what and how often
_____

Please indicate what immunizations you have had ☐ DPT (diphtheria, pertussis, tetanus)	**☐ Haemophilus influenza B**	**☐ Hepatitis A**
☐ Tetanus booster; when? _____	**☐ "Flu"**	**☐ Hepatitis B**
☐ MMR (measles, mumps, rubella)	**☐ Polio**	**☐ Smallpox**

Breakfast_____

Lunch_____
_____

Dinner_____
_____

Snacks_____
_____

Beverages (and total quantity)
_____
_____

Family History

Indicate if a close relative (parent, child, sibling) has had any of the following: Please indicate which family member
Allergies
Asthma
Heart Disease
High Blood Pressure
Cancer
Diabetes
Depression
Other Mental Illness
Drug Abuse/Alcoholism
Kidney Disease
Other