

Name: _____ Age _____ Email: _____

Phone # : _____ Referred by: _____

Best time to call me _____

Please read and sign

I am here to learn about nutrition and am seeking information about a wholesome diet, food supplements, herbs and natural therapies. I understand that Pat Block is a licensed *Doctor of Natural Medicine* and a *Certified Natural Health Professional* **not a licensed medical doctor**. I am not seeking a medical diagnosis, treatment or prescription for any illness. If I have a medical problem I will see my medical doctor.

Date _____ Signed _____

Blood Type _____ (not required)

Medical diagnoses (doc said I have..) _____

...and the drugs/OTCs you are taking _____

Please number symptoms below with a 1, 2, or 3 in the blank provided according to this scale (elaborate where lines are provided)

Leave Blank if it is never a problem Enter a **1** for a Slight problem = occurs so infrequently I ignore it

2. Moderate problem = bothersome but I'm dealing with it

3. Major problem = one of the main reasons I'm here

<input type="checkbox"/> Abdominal pain __ upper, __ lower	<input type="checkbox"/> Food sits on stomach after eating	<input type="checkbox"/> Muscle or leg cramps ___ at night, ___ with inactivity ___ with exercise
<input type="checkbox"/> Acid indigestion/ heartburn	<input type="checkbox"/> Foot / heel pain	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Addictions to _____	<input type="checkbox"/> Frequent thirst	<input type="checkbox"/> Numbness, where? _____
<input type="checkbox"/> Allergies, food _____	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Physical trauma as _child, _adult
<input type="checkbox"/> Allergies, respiratory _____	<input type="checkbox"/> Headaches or migraines	<input type="checkbox"/> PMS
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart beats irregular	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Anger, excessive	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Restless dreams or nightmares
<input type="checkbox"/> Anxiety, nervousness, panic attacks	<input type="checkbox"/> High blood pressure ___ / ___	<input type="checkbox"/> Ringing in the ears
<input type="checkbox"/> Appetite, __ poor, __ excessive	<input type="checkbox"/> High cholesterol _____	<input type="checkbox"/> Sinusitis or sinus congestion
<input type="checkbox"/> Back pain __ upper, __ mid, __ lower	<input type="checkbox"/> Hot flashes ___ at night only	<input type="checkbox"/> Skin (acne, rashes, lesions etc)
<input type="checkbox"/> Bad breath or body odor	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sleep problems: ___ falling asleep; ___ staying asleep; ___ awake tired
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Impotence (males only)	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Burning feet at night	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Snoring / sleep apnea
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Infections often, where? _____	<input type="checkbox"/> Stiffness ___ with inactivity
<input type="checkbox"/> Cold hands / nose / feet / skin	<input type="checkbox"/> Infertility	<input type="checkbox"/> Stomachache, when? _____
<input type="checkbox"/> Congested lungs/ wheezing	<input type="checkbox"/> Intestinal gas, bloating, belching	<input type="checkbox"/> Stress
<input type="checkbox"/> Constipation or dry stools	<input type="checkbox"/> Irritable often	<input type="checkbox"/> Surgeries _____
<input type="checkbox"/> Coughing, chronic	<input type="checkbox"/> Itching, skin, where? _____	<input type="checkbox"/> _____
<input type="checkbox"/> Cravings for _____	<input type="checkbox"/> Itchy nose or ears	<input type="checkbox"/> Sweaty hands / feet
<input type="checkbox"/> Depression	<input type="checkbox"/> Joint pain or gout	<input type="checkbox"/> Swollen lymph glands
<input type="checkbox"/> Diarrhea/ loose stool	<input type="checkbox"/> Keyed up - cannot calm down	<input type="checkbox"/> Teeth grinding
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Loss of sexual desire	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Dizziness or light-headedness	<input type="checkbox"/> Loss of smell / taste	<input type="checkbox"/> Viral (_ColdSores, _Genital, _Shingles)
<input type="checkbox"/> Drowsy often, when? _____	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Water retention, swelling or edema
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Lump in throat sensation	<input type="checkbox"/> Watery eyes, runny nose
<input type="checkbox"/> Dry __ eyes, __ nose, __ mouth	<input type="checkbox"/> Menstrual disorders _____	<input type="checkbox"/> Weakness, where? _____
<input type="checkbox"/> Emotional trauma as _child, _adult	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Wounds that won't heal
<input type="checkbox"/> Eye bags / dark circles	<input type="checkbox"/> Mucus excess / constant drainage	<input type="checkbox"/> Yawns often
<input type="checkbox"/> Fatigue, chronic	<input type="checkbox"/> Nausea	<input type="checkbox"/> Yeast infections
<input type="checkbox"/> Fear, excessive	<input type="checkbox"/> Muddled thinking, confusion	
<input type="checkbox"/> Fever often	<input type="checkbox"/> Muscle tension / trigger points	

Return both sheets

Check if you have a family history of __ heart disease, __ cancer, or __ diabetes

by fax (757) 867-8241

Symptom / Diagnosis / Complaint / Problem (most important 1 st)	How long have you had this?	What do <u>you</u> think it is the result of...or related to... (not what the doc said)	What are some things that have helped you with this? (if any)

Mail Consult Fee to: Pat Block, ND, 102 Kay Circle, Yorktown, VA 23693

- I will purchase the herbs myself (consult fee of \$30 sent to above address)
 - Please have the herbs shipped to me (consult fee of \$15 sent to above address)
- We will need your address and credit card info to ship you the herbs.

Note - If dosage reduction results in return of symptoms, increase dosage again

No. bttls	Nutritional Intervention (take supplements before meals)	Week 1			Week 2				Week 3				Week 4			
		B	L	D	B	B	L	D	B	B	L	D	B	B	L	D

Other Instructions or Therapies: www.PatBlockND.com
How To Get Well / Library / Recipes / NewClient
You can email me at PatBlockND@yahoo.com
or, PatBlockND@aol.com (or both)

Next Appointment (in ___ weeks/ months):

Make sure to read 'What to Expect on an Herbal Program' on my website