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Name _____ Date of Birth _____
 Reason for Visit _____ Date _____

Current Health Problems/Diagnoses		Family Disease History Self, Parent, Grandparent			S	P	G	Current Vitamins, Herbs or Supplements	Current Prescription Medications		
1.		Asthma						1.	1.		
2.		Arthritis						2.	2.		
3.		Alcoholism						3.	3.		
4.		Epilepsy						4.	See space at bottom of 2 nd column		
5.		Thyroid						5.			
		Obesity						6.	Nutrition		
									Estimate how often you use.		
Surgeries/Hospital Stay		Year		Heart Disease				7.	Daily / Weekly	#/wk	
1.				High Blood Pressure					Wheat, Bread, Muffins		
2.				Mental Disorder					Drug Allergies?	Pasta	
3.				Cancer					1.	Rice, Oatmeal, Barley	
4.				Other:					2.	Citrus (oranges, etc.)	
								Airborne Allergies?	<input checked="" type="checkbox"/>	Soda Pop	
Rate Current Wellbeing		0-10		Personal Health History			Smoke			Coffee/Black Tea (circle)	
Poor 1-3 Good 4-6 Excellent 7-10				Current , Past			C	P	Dust		Tobacco / Cigarettes
Job or School				Fatigue					Pollen		# yrs / When quit?
Financial / Money				Low Blood Sugar					Weeds		Beer / Wine / Spirits
Primary relationship				Poor Sleep					Grass		# yrs / When quit?
Family, Parents, Children				Anxiety					Trees		Aspirin
Freedom from Allergies				Depression					Molds		Tylenol
Overall Freedom from Stress				Overweight					Other		Nutrasweet/Artif sweet
Overall Sleep				Headache							Cheese
Overall Physical Energy				Neck Pain					Food Sensitivities?	<input checked="" type="checkbox"/>	Milk
Overall Mental Energy				Back Pain					Nightshade		Fried Foods
Other Challenges:				Joint Pain					Dairy		Marg or Butter (circle)
				Allergies, Hayfever					Wheat		Beef / Burgers / Steak
Have you ever used:		Y/N		Sinusitis					Alcohol		Bacon, Bologna, Salami
Vitamin Therapy				Recurrent Colds, Flu					Other:		Turkey, Chicken
Herbal Medicine				Other Recurrent Infections							Tuna, Other Fish
Homeopathic Medicine				Ear/Eye Problems					Chemical Sensitivities?	<input checked="" type="checkbox"/>	Beans, Peas
Acupuncture				Poor Digestion, Gas					Perfumes		Salad
Spinal Manipulation				Recurrent Diarrhea					Soaps		Fresh Fruit
Therapeutic Fasting				Constipation					Odors		Juice, Bottled or frozen
Massage Therapy				Abdominal Pain / Bloating					Solvents		Juice Fresh: veg/fruit
Naturopathic Physician				High Blood Pressure					Other		Fresh Vegetables
				Elevated Cholesterol or Fat							Cooked vegetables
List your Health Goals				Premenstrual Symptoms					Current Medical Providers		Other
1.				Menstrual Problems					M.D./ D.O.:		Mark Problem Areas below
2.				Menopause					Chiropractor:		
3.				Hot Flashes					Naturopathic Dr.:		
4.				Breast Problems					OB/GYN:		
5.				Alcoholism					Psychologist:		
				Drug Addictions					Other:		
How did you hear about us?		<input checked="" type="checkbox"/>		History of Abuse					Exercise / Times Per day/week		
Doctor:				Sexual Dysfunction					Walk/Run:		
Friend:				Other, Please list:					Swim:		
Yellow pages									Bike:		
Article in Media									Aerobics:		
Clinic Sign									Other:		