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 CTN. 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.

_____

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 .

List all medical conditions you are now being treated for:_____
_____
_____

Any blood relative ever had: Please Circle 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

_____