



Wise Woman
Natural Health Center

810 E. Ashman Midland, MI 48642

Dr. Helen Kociba ND, CHBD
Traditional Naturopathic Doctor
Certified Birth Doula
(989) 488-8660

New Client Information Form

Blood Type

Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell: _____ Texting okay? Y / N

May we leave a message? _____ Email: _____

Occupation: _____ Referred by: _____

Date of Birth: _____ Age: _____ (Twin / Single) (Vaginal / C-Section)

Emergency Contact/Relationship: _____ Phone: _____

Marital Status: _____

Spouse's Name: _____ Spouse's Occupation: _____

Other People in your Household

Please mark all of the alternative treatments you have tried for your condition(s):

What worked the best?

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Colonics | <input type="checkbox"/> Ayurveda |
| <input type="checkbox"/> Naturopathic Doc | <input type="checkbox"/> Massage | <input type="checkbox"/> Homeopathy |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Reiki | <input type="checkbox"/> Light Therapy |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Nutritional | <input type="checkbox"/> Meditation/Prayer |
| <input type="checkbox"/> Iridology | <input type="checkbox"/> Cleansing | <input type="checkbox"/> Other |

Recent Medication History

When was your last Vaccination? *Indicate which one please:* _____

When was your last course of antibiotics? _____ Length of time? _____

➤ Have you been on antibiotics/steroids often in your lifetime? Y /N

Have you taken steroids in the last year? Y / N For what condition? _____

Other information: _____

Please list any allergies to medications: _____

List any medications you are taking and explain for what reason:

Please list any supplements or herbs taken regularly:

BODY SYSTEM HEALTH PROFILE

Please check any item listed below:

- Heart/Circulatory
- Previous heart attack or stroke
 - High Blood Pressure
 - Low Blood Pressure
 - Sinus congestion
 - High Cholesterol
 - High Triglycerides
 - Poor circulation
 - Cold hands & feet
 - Anemia
 - Dizziness
 - Ringing in the ears/Tinnitus

- Respiratory/Immune
- Allergies
 - Asthma
 - Lung congestion
 - Cough
 - Sinus infection
 - Recurrent influenza
 - Tonsillitis
 - Ear aches

- Joint Health
- Swelling in ankles/joints
 - Stiffness
 - Backache
 - Arthritis - where?
 - Low back pain
 - Gout

- Skin
- Acne
 - Eczema
 - Psoriasis
 - Slow wound healing
 - Warts
 - Bruise easily
 - Moles
 - Skin cancer

- Gastrointestinal System
- Halitosis (bad breath)
 - Reflux/regurgitation/GERD
 - Ulcers
 - Bloating
 - Gall stones
 - Hypoglycemia
 - Constipation
 - Diarrhea
 - Flatulence/Gas
 - Irritable bowel
 - Hemorrhoids
 - Anal Bleeding

- Urinary
- Fungal, bacterial infections
 - Bladder infections
 - Water retention
 - Painful urination
 - Excessive urination
 - Blood in urine

Bowel Movements

per day: _____

Food Triggers:

Do you smoke? _____ How often/how many packs per day? _____

Alcohol Use? Y / N How often? _____ Do you drink diet pop? _____

Females Only

Age of first menses: _____ Where they regular / irregular? # of Pregnancies: _____

Please give any details you would like to share: _____

What are your health goals for this visit?

- 1. _____
- 2. _____
- 3. _____

Anything else you want to share?

Consent for Services

Before we begin our first session, it is important for you to understand my role as a consultant and what to expect in our session together. It is my responsibility to inform you that I am not a medical doctor; therefore, I do not diagnose or prescribe. Rather, the sessions will be a reflection of empowerment where my role as the consultant is to educate and empower you, the client, to take active participation in your own health. Additionally, you will gain a greater knowledge for how your body functions in relation to your concerns while expanding your choices for healthy lifestyle changes.

After reading the above, I _____, acknowledge that I am making a personal choice to receive recommendations from Helen Kociba, a Naturopathic practitioner. I understand that it is also my personal choice to act, or not, on any of the recommendations provided.

NOTE: Your intake form information is private and only used for healthcare purposes. Also, I do not adjust any of the current medication you are taking. If you are seeking change to your daily regimen, please consult with your prescribing physician.

Print Name: _____

Signature: _____ Date: _____