JODY SHEVINS, ND
600 S. Airport Rd., Bldg. A, Suite 203, Longmont, CO 80503 ph (303) 494-3713 fax (303) 776-0387

Greetings,

It is extremely helpful to have you prepare this information before your first appointment. This ensures that our visit is as thorough and useful as possible. These forms include a questionnaire, diet diary, disclosures and consent forms. Please complete all four pages of the questionnaire, with particular attention to the history. You can fill out the diet diary for any 3 days in a row between now and your appointment.

Thank you for putting your time into this preparation and please remember to bring them with you to your appointment.

If you need to cancel your appointment, please call at least 24 hours in advance. Barring emergencies, there will be a charge for missed first appointments not cancelled at least a day ahead.

Payment is expected at the time of your visit. We accept cash, check or credit card.

I look forward to meeting with you.

Sincerely,

Jody K. Shevins, ND

dr.shevins@gmail.com

IDENTIFICATION DATA **Please print**	Date_____ Gender ____
Name_____	Date of Birth
Address_____	Single__Married__Sep__Divorced__Widow __Cohab__.
City_____ State____Zip_____	Occupation _____ .
Home Phone_____	School currently attending_____ .
Work Phone_____	Cell Phone_____ .

Indicate below ailments which have affected your relatives. Do/did they have the same ailments as you? Possible ailments: AIDS, alcoholism, allergies, arthritis, asthma, cancer, diabetes, drug addiction, epilepsy, frequent colds, gonorrhea, gout, hay fever, heart problems, mental illness, neurological problems, obesity, pleurisy, pneumonia, skin problems, syphilis, thyroid problems, tuberculosis, ulcers, warts.

RELATIVE	AGE NOW	AGE AT DEATH	HEALTH CONCERNS
MOTHER			
FATHER			
SISTERS			
BROTHERS			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
MATERNAL AUNTS/UNCLES			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			
PATERNAL AUNTS/UNCLES			

Referred by_____

What would you like cured? Please be brief. Details will be obtained during your consultation.

Are you or have you been exposed to chemicals, pesticides, etc.? How did they affect you?

Children: first names	Age	Health Concerns

If applicable:
Spouse's name_____ Age____
Occupation_____
Spouse's health concerns:

How much do/did you smoke? When and for how long?	How much alcohol do/did you drink? What and when?
Describe your interests, hobbies, recreational activities.	Do you exercise? What type, how often and for how long?

Please list any medications, hormones and/or supplements you are currently using and their dosage:

YOUR HEALTH HISTORY

Please write a brief outline of your life history. Beginning with birth or early childhood, list **major illnesses, injuries, hospitalizations, significant turning points or major events in your life, any periods of heavy use of alcohol, cigarette, coffee, pharmaceutical or recreational drugs.** For women, please include **events related to your reproductive system (first period, pregnancies, abortions, birth control, menopause.)** Please keep it simple, we will go into detail as needed.

Diet Diary: Please list everything you eat and drink for 3 consecutive days

DAY ONE	DAY TWO	DAY THREE