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DATE \_\_\_\_\_

### PATIENT PROFILE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Nickname: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

**A note to our patients:** Please complete this two-sided questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

### PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		
5.		

What goals do you have for your visit at the clinic today? \_\_\_\_\_

Have you ever consulted a Naturopathic physician before? (Please Circle) Yes No

Do you have any questions about our clinic or the care that you've chosen today? \_\_\_\_\_

Please list prescription medications that you are currently taking, with dosages:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

