Adult Nutrigenomic Consultation History Brief

Patient Name: ___________________________________ Date of Birth:_____________________________

Address: ____
Email Address:____

Cell Phone: __________________________Other Phone(s):_______________________________________
Can we leave a message on this number? ______________________

Primary Care Provider:____
Phone:____

Have you ever received a previous diagnosis related to neurological health? If so, what? ____

Have you received any other medical diagnosis?____
____

Current Medications:
____
____
____

Current Vitamins or Supplements: (please include brands and doses)
____
____
____
____

Any known supplement or medication allergies?____

Have you had any recent hospitalization or surgeries?
____
____

Do you have any known food allergies or sensitivities?
____
____

Prior medications used to health conditions (including supplements):
____
____
____

What was your experience with these medications/supplements?____
____
____

Please describe your diet:
____
____
____
____
____
____
____
____

Are there any particular concerns that you have that you would like to discuss today?
____
____
____
____
____