Date:

First Name: Last Name: Date of Birth:

Address: Postal Code:

Telephone: (Home) (Business) (Cell)

Email:

Occupation:

Who may we thank for your referral?

Physician Information

Family Doctor Name:

Address: Phone:

Reasons for your consultation; please circle any of the following that relate to you:

Anorexia	Bulimia	Asthma	Atherosclerosis	Constipation
Diarrhea	Diabetes	Diverticulitis	Dyslipidemia	Gout
Blood Sugars	Insulin Resistance	Weight Gain	Weight Loss	Thyroid
↑Blood Pressure	↑Cholesterol	↑Triglycerides	Irritable Bowel	Menopause
Osteoporosis				

Other chronic conditions?

Have you ever had surgery?

Medications:

Supplements/Vitamins:

Have you ever been on any special diet before?

Do you have any food allergies or dislikes to food?

Do you exercise? Not currently 1 x week 2 x week 3 x week 4 x week 5 x week

Any other comments you wish to share?

Signature (type your name for a digital form):

The information on this form is confidential. Please be advised that there is a 24-hour cancellation policy.

Once complete, please email your form back to us at info@cassandrareid.com

Questions? Call us: 416.488-8061