J.J.'s Prescription Specialties

337-562-7979
4070 Nelson Road, Suite 200
Lake Charles, LA 70605

Consultation Form

Name

First Name

Last Name

Phone

Email

Address

Street Address

Address Line 2

City

State/Province/Region

ZIP/Postal Code

Have you ever had problems with any of the following? (Check all that apply)

- ☐ Adrenals
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding
- ☐ Breasts
- ☐ Burping/Gas
- ☐ Cancer
- ☐ Circulation
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion
- ☐ Edema
- ☐ Fainting
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Galbladder
- ☐ Headaches
- ☐ Heart
- ☐ Heartburn
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Insomnia
- ☐ Kidneys
- ☐ Liver
- ☐ Low Blood Pressure
- ☐ Lungs
- ☐ Menopause
- ☐ Numbness in Hands or Feet
- ☐ Ovaries
- ☐ Pancreas
- ☐ PMS
- ☐ Prostate
- ☐ Skin/Acne
- ☐ Spleen
- ☐ Throat
- ☐ Thyroid
- ☐ Ulcers
- ☐ Weight
- ☐ Other

If other, please describe:

Do you eat out more than 5 times per week?

- ◯ Yes
- ◯ No

Do you eat breakfast regularly?

- ◯ Yes
- ◯ No

Do you eat fast food daily?

- ◯ Yes
- ◯ No

Do you drink coffee on an empty stomach?

- ◯ Yes
- ◯ No

Do you eat organic fruits and/or vegetables daily?

- ◯ Yes
- ◯ No

Do you smoke?

- ◯ Yes
- ◯ No

Are you currently pregnant, nursing or trying to become pregnant?

- ◯ Yes
- ◯ No

About how many servings of refined sugar do you eat daily? (candy, pastries, most desserts, anything with syrup, malt, or words ending in -ose in the ingredients)

About how many servings of processed carbohydrates do you eat daily? (most baked goods, pasta, white bread, soft drinks, etc.)

About how many servings of dairy do you have per day?

About how many servings of processed meats do you eat daily? (hot dogs, sausage, bologna, etc.)

What is your occupation?

Are you mostly active or mostly stationary during the day?

How many hours do you work in a typical week?

Do you exercise 3 times per week or more?

Check any below that you regularly come into contact with at home or the workplace:

- ☐ Humidity
- ☐ Mildew
- ☐ Old carpet (4+ years)
- ☐ Smog
- ☐ Insect repellant
- ☐ Lawn chemicals
- ☐ Garden chemicals
- ☐ Chemical cleaning agents
- ☐ Poor ventilation
- ☐ High traffic areas
- ☐ Florescent lighting
- ☐ Air conditioning

Surgeries

List all surgeries and the cause.

Year	Surgery	Cause

Allergies

List all food and medicinal allergies and a description of the reaction.

Cause	Reaction

Medications

List all medications and supplements you're currently taking including prescriptions, over-the-counter, vitamins, etc.

Medication	Strength	Date Started	Times Per Day

Past Medications

List all medications previously taken in the last two years.

Medication	Strength	Date Started	Times Per Day

If there's any other medication or medical history you think we should know about, please give us the details below.

Reason for Consultation

Please use the space below to tell us about the reason for your visit and what you'd like to achieve from this consultation.

What days are you available?

- [ ] **Monday**
- [ ] **Tuesday**
- [ ] **Wednesday**
- [ ] **Thursday**

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*Please print out the completed form and fax it to **337-562-2343***
*or bring it to **JJ's Prescription Specialties.***