YEH CENTER OF NATURAL MEDICINE, INC.
195 North Second Avenue
Upland, California 91786
(909) 946-6444 • (909) 946-1099 FAX

PERSONALIZED MEDICAL CONSULTATION - FORM B

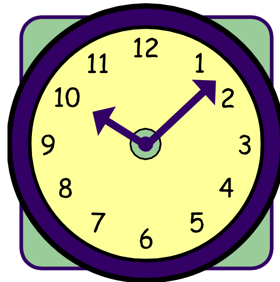
(Please Print)

First Name: _________________ Middle Initial: _____ Last Name: _________________

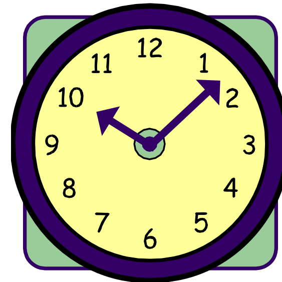
EATING PATTERN:

How would you rate your appetite? o good o fair o poor
How many meals do you eat each day? ______
How many times do you snack each day? _____
Do you have strong support and sufficient help from your family members and friends to maintain good health and proper diet? o yes o no

On the clocks below, please circle the times when you eat daily meals.
On the clocks below, please "x" the times when you normally snack.
Do you keep this consistent pattern of eating? o yes o no
If no, please explain: ____



12 a.m. – 11 a.m.



12 p.m. – 11 p.m.

SPECIAL DIETS:

Are you on a special diet? o yes o no
If yes, please explain: ____
____

Is anyone in your family (those living with you) on a special diet? o yes o no
If yes, please explain: ____
____
Does it affect your eating habits and/or diet? ___________________________________
____

Do you have difficulty eating? o yes o no
If yes, please explain: ____

____

Do you suffer from anorexia, bulimia, or compulsive eating? o yes o no
If yes, please explain and list foods: ______________________________

____

Do you turn to food as a way of coping with stress and/or depression?
o yes, always o yes, sometimes o no, never
If yes, please explain: ____

____

Do you suffer from food allergies? o yes o no
If yes, please explain and list foods: ______________________________

____

SMOKING, DRINKING, DRUGS:

Do you smoke cigarettes? o yes o no — If yes, please indicate frequency: __________
Do you drink alcohol? o yes o no — If yes, please indicate frequency: __________
Do you take "street drugs"? o yes o no — If yes, please indicate frequency: __________

CURRENT FOOD FREQUENCY CHECKLIST:

Food	**Servings, Amount & Frequency Per Day**	**Preparation Method**
Vegetables	____________	____________________
	____________	____________________
	____________	____________________
	____________	____________________
Fruits	____________	____________________
	____________	____________________
	____________	____________________
	____________	____________________
Animal Meats & Seafood	____________	____________________
	____________	____________________
	____________	____________________
	____________	____________________
Grains & Small Seeds	____________	____________________
	____________	____________________
	____________	____________________
	____________	____________________

Beans, Nuts & Large Seeds	________________	____________________________
	________________	____________________________
	________________	____________________________
	________________	____________________________
Dairy Products	________________	____________________________
	________________	____________________________
	________________	____________________________
	________________	____________________________
Water & Beverages	________________	____________________________
	________________	____________________________
	________________	____________________________
	________________	____________________________

The information I have provided is true and accurate to the best of my knowledge. I understand that this information will be held in strict confidentiality between the medical staff at Yeh Center of Natural Medicine, Inc. and myself.

The purpose of this “Medical Consultation” is to familiarize the patient with herbal medicine, nutrition, and diet on an individualized basis. The manual does not make any health claims, and the information introduced does not take the place of physician’s care, medical procedures, lab tests, or any necessary medication.

Yeh Center of Natural Medicine, Inc. also does not in any way encourage any person to try to heal themselves or to stop their current medical care and supervision, as all medical treatment requires the knowledge and skill of a trained professional. Due to the personalized nature of this medical consultation program, long hours are spent putting it together. Therefore, there is no exchange or refund for this consultation. I have read and understand the above statements.

Print Name: ________________ Signature: _______________ Date: ___________

After completing this form, please make a copy and return it to the receptionist office. Thank you.