



aVerdure

South Hills PT Clinic
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Initial Consultation

Date: _____

Name: _____

Email: _____ Phone: _____

Address: _____

What are your health concerns? _____

What would you like to accomplish from this consultation? _____

What are you taking now to help yourself? _____

Are you on medications? If so, for what? _____

Do you like to cook? _____ Do you eat 3 meals/day? _____

What kind of work do you do? _____

Do you crave sugar? _____ Do you crave salt? _____

Do you wake at night to urinate? _____ How many times per night? _____

Do you feel tired, bloated, and/or gassy after meals? _____

Do you experience constipation or diarrhea often? _____

Are you a vegetarian or vegan? _____

Is there any other information you feel important to include?
