Natural Solutions For You

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PATIENT CARE RECORD/CASE HISTORY FORM

Date _____

Name_____

Phone (Home) _____(Cell)_____(Work)_____

Occupation _____No. hrs/day (week)_____

Address_____

_____

Date of Birth _____Weight _____Height_____

Referred by _____

Main reason for coming_____

_____

Date of last physical examination_____Result _____

List all supplements (include dosage and brands): _____

_____

Family Doctor's name _____

Daily consumption: Coffee_____ Tea _____ Alcohol _____ Smoke _____

Food_____Appetite_____

Exercise _____Sleep pattern_____

Epilepsy _____Anemia_____ Diabetes_____ Bruise easily_____

Heart disease_____BP_____Headaches/Migraines_____

Earaches _____ Sinus / Allergies _____

No. Of colds/year _____ Chronic cough _____

Indigestion/Pain in abdomen_____Constipation_____

Liver/Gall bladder/Kidney/Cystitis _____

_____

Fainting/Dizziness _____Leg cramps _____

Cysts _____Sensitive skin _____Rashes _____

Stiff/painful joints _____

Arthritis_____

Pain/tension in a back/neck_____

Surgery/Hospitalization _____

Accidents/Fractures_____

Menstruation/Pregnancies/I.U.D._____

Other relevant information_____

_____

Please list your major health concerns:

_____

_____

_____

What relieves your condition?

_____

_____

_____

What aggravates your condition?

_____

_____

_____

_____

SIGNATURE