Natural Health Care Centre Treatment History

Name:____________________ Date:_____________________

Who referred you to this office? Name:
☐Yellow Pages ☐Advertisement ☐Sign ☐Other:

Present symptoms: What is your major complaint or condition you want to improve?

____

When did you first notice major complaints? ______________________________________

What brought it on? ____
____

What activities aggravate the condition?____
____

Is this condition getting progressively worse?☐ Yes ☐ No
Please explain: ____
____

Does this condition interfere with work? ☐ Yes ☐ No Sleep? ☐ Yes ☐ No
Daily Routine? ☐ Yes ☐ No
Please explain: ____
____

What have you done to get relief? ____
____

Has there been a medical diagnosis? ☐ Yes ☐ No
If so, by whom? ____
Please explain: ____

Have you had x-rays taken? ☐ Yes ☐ No
If yes, by whom? ____

What are your intentions or expectations for this visit? ________________________
____
____
____

Are you now under medical/therapeutic treatment? ☐ Yes ☐ No
If yes, for what condition? ____
____

Please list your care provider's name and phone number: ______________________
____
____

List any medications (including aspirin) and nutritional supplements you are taking:
____
____
____

Describe the exercise activities you do (include frequency): ___________________
____
____

List other therapies you receive: ____
____
____
____

Please list (date and description) any accidents or operations: __________________
____
____
____

Please list any additional comments regarding your health and well-being: _______
____
____
____