VICTORIA NATURAL HEALING CLINIC

Name_____Tel(H)_____(W)_____(C)_____

Address

_____Postal Code_____

Email_____Contact in emergency_____

Occupation_____ Age_____Birthdate_____

How did you hear about the clinic_____? Do you have extended Medical care_____?

What drugs are you taking now? For what purpose?

_____

Do you have any allergies? If yes, what are they?

_____

Main concern for the visit

_____

_____

_____

_____

Past Medical History

_____

Family History

_____

_____

_____

_____

General Health Information:

Diet Habit

_____

_____

_____

Life-style / sleep / excercises

_____

_____

Sexual HIstory / menstrual history / pregnancy & delivery history / any STD's you are aware of?

_____

_____

Emotions

_____

_____

The following is for the practitioner to fill

Observation:

Spirit_____

Complexion _____

Tongue

_____

Palpulation:

Pulse_____

Abdomen

_____

Chest _____

Other _____

Other info: (Blood pressure & temperature)