NATURAL ORIGINS
WHOLE BODY WELLNESS

PERSONAL INFORMATION

FULL NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

E-MAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT US/ REFERRED BY? _____

HEALTH INFORMATION

OCCUPATION _____

DOB _____ AGE _____ SEX M / F ☐ ☐

HEIGHT_____WEIGHT _____

OVERALL HEALTH: EXCELLENT / GOOD / FAIR / POOR/ EXCELLENT

CHIEF COMPLAINT: _____

_____

PREVIOUS TREATMENTS : _____

_____

COMPLAINTS/CONCERNS: _____

_____

CURRENT MEDICATIONS/SUPPLEMENTS: _____

_____

ALLERGIES: _____

_____

PHYSICIAN OR HEALTH CARE PROFESSIONAL?(NAME & SPECIALTY)

_____

LIFESTYLE & HABITS

SMOKING: CIGARETTES/DAY: _____

COFFEE: CUPS/DAY: _____

ALCOHOL: DRINKS/DAY: _____

VAPE/THC/ SUBSTANCE USE (IF SO, WHAT KIND)

_____

_____

MEDICAL HISTORY

MAJOR INJURIES/ILLNESS (DATE) _____

_____

SURGERIES OR OPERATIONS (DATE) _____

_____

GALLBLADDER REMOVAL Y/N: _____

HYSTERECTOMY (PARTIAL/FULL)Y/N: _____

APPENDIX REMOVAL Y/N: _____

PAST ACCIDENTS/ SCARS _____

_____

DO YOU PARTICIPATE IN OR CURRENTLY HAVE ANY OF THE FOLLOWING? YES OR NO

INJECTIONS: (FILLERS, BOTOX, STEROIDS) _____

IMPLANTS: (MEDICAL DEVICE, BIOCOMPATIBLE MATERIAL) _____

CHIROPRACTOR:_____

MASSAGE THERAPY: _____

EXERCISE: _____ HOW OFTEN: _____

HOURS OF SLEEP/QUALITY: _____

DIETS/FOOD RESTRICTIONS: _____

BOWEL MOVEMENTS REGULAR Y/N: _____

MENSES REGULAR Y/N: _____

SYMPTOMS: _____

PRE / PERI / POST MENOPAUSE (CIRCLE)

MARITAL STATUS: S / M / D / W (CIRCLE)

OVERALL HEALTH OF FAMILY _____

OF CHILDREN _____

AGES _____

ANY PHYSICAL CONDITIONS OR CONCERNS? _____

_____

FAMILY HISTORY OF: CANCER / DIABETES / HEART / OTHER:

_____

WHAT CAN WE DO TO MAKE YOU HAPPIER? _____

_____

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OFFICE USE:

HISTORY: _____

HRV:

O- _____

V-_____

L- _____

B- _____

S- _____

VB- _____

RECOMMENDATIONS: _____