Head to Heal Family Wellness Centre for Naturopathic Medicine & The Bowen Technique

Name:	Age:	Date of Birth:
Address:	City:	Postal Code:
Home Tel:	Work Tel:	E-mail:
Marital Status:	Number of Children:	Ages:
Occupation:	How Long:	Employer:
Referred by:	Insurance Provider:	

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE FOR YOU?	SINCE?	CAUSES?

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?	SINCE?	ANY ADVERSE EFFECTS?

CHECKMARK EACH OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

Abscesses		Depression		Heart Disease		Mononucleosis		Rheumatic Fever		Syphilis	
Alcoholism		Diabetes		Hepatitis		Mumps		Rubella		Tonsillitis	
Allergies		Emphysema		Herpes		Palsy		Scarlet Fever		Tuberculosis	
Anemia		Epilepsy		Influenza		Pelvic Problems		Sexual Abuse		Typhoid Fever	
Arthritis		Gall-Stones		Kidney Disease		Peritonitis		Skin Disease		Venereal Warts	
Asthma		Goitre		Leukemia		Pleurisy		Strep Throat		Warts	
Cancer		Gonorrhea		Malaria		Pneumonia		Sinusitis		Whooping Cough	
Chicken Pox		Gout		Measles		Parasites		Sunstroke		Worms	
Cold Sores		Hay Fever		Miscarriage		Prostatitis		Stroke		Yellow Fever	

ANY OTHER MAJOR CONDITIONS?	SINCE?	COMPLICATIONS?

WHAT OPERATIONS HAVE YOU HAD?	WHEN?	COMPLICATIONS?

ACHES & PAINS?	WHERE?	SINCE WHEN?

WHAT MAJOR INJURIES HAVE YOU HAD?	WHEN?	LONG-TERM EFFECTS?

WHAT VACCINATIONS HAVE YOU HAD?	WHEN?	ANY ADVERSE EFFECTS?

HOW MUCH OF THE FOLLOWING ARE YOU USING?

Coffee:	Tea:	Alcohol:	Tobacco:	Recreational Drugs:

INDICATE WHICH OF THE FOLLOWING AILMENTS HAVE AFFECTED YOUR RELATIVES:

Alcoholism	Asthma	Diabetes	Gout	Insanity	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

ANY OTHER MAJOR AILMENTS? WHO?

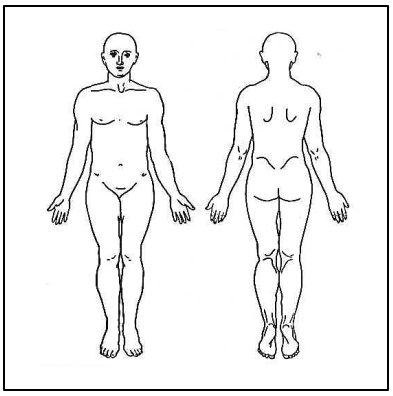
ARE YOU PREGNANT OR TRYING TO CONCEIVE?

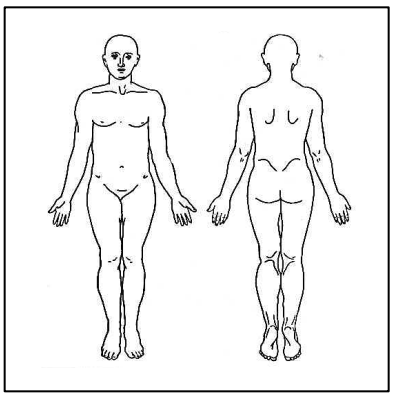
IN YOUR OWN WORDS PLEASE DESCRIBE YOUR NATURE?

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER PHYSICIANS or PRACTITIONERS?

Dr.	For:	Treatment:
Dr.	For:	Treatment:
Dr.	For:	Treatment:

PLEASE CIRCLE OR DRAW IN THE AREAS OF YOUR PAIN – IF NECESSARY, USE BOTH DIAGRAMS TO HELP EXPLAIN THE HISTORY OF YOUR SYMPTOM(S).





I have read and signed the Informed Consent Form of the Head to Heal Centre for Naturopathic Medicine & the Bowen technique

Signed: _____ Date: _____