

**HOLISTIC HEALING ARTS**  
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Doctor of Naturopathic Medicine  
Reg. #1940

**REACTIVATION INTAKE FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: (if changed) \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Name

Telephone Number

Does your insurance cover consultations with a doctor? \_\_\_\_\_ Remedies Recommended? \_\_\_\_\_

How can we help you? (what is your health problem?) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did your problem start? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Are they related symptoms? \_\_\_\_\_

Are there any other health problems that you would like to have treated?

List in order of importance:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

What treatments, medicines, drugs are you taking or have taken? WHEN and for HOW LONG? How did these methods affect you?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Operations (surgeries) since last visit?

Date

What effect did it have on you?

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What supplements/natural remedies are you taking now?

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What has changed since your last visit? \_\_\_\_\_

Gotten better? \_\_\_\_\_

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Gotten worse? \_\_\_\_\_

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No difference? \_\_\_\_\_

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(Please indicate painful areas with an "X")

