Holistic Healing Arts

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Reactivation Intake Form

Name:____Date:_____________________________________

Address: (if changed)__________________________________Email:____________________________________

City:__________________________Postal Code:____________________Telephone:________________________

Occupation:______________________________Employer:____

Emergency Contact:____
Name Telephone Number

Does your insurance cover consultations with a Naturopathic 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.____

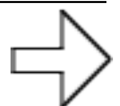
4.____

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

____

____

Turn Over



Operations (surgeries) since last visit? Give date What effect did it have on you?

______________________ __________ ______________________

______________________ __________ ______________________

What supplements/natural remedies are you taking now?

____

____

____

What has changes since your last visit?______________________________

Gotten better?____

____

____

Gotten worse?____

____

____

No difference?____

____

____

(Please indicate painful areas with an "X")