

Personal Information

<div>Mr</div>	
Nicolai	Coaster
Valdue	7777700998
11111111111	123123123123
nicolai@yopmail.com	01/01/1970
Bharuch, Gujarat, India	Matruchhaya residency
Tavra	Gujarat
392011	India
Web Developer	<div>Male</div> <div>Female</div> <div>Other</div>

Emergency contact

fname	lname
Mobile phone	relation

Referral source

How did you hear about this clinic?

Family or Friends

Health History

If you have a history of any of the following conditions, please select below.

- | | | |
|---|---------------------------------------|--------------------------------------|
| <input type="radio"/> Heart disease | <input type="radio"/> Diabetes | <input type="radio"/> Asthma |
| <input type="radio"/> Severe weight loss/gain | <input type="radio"/> Headaches | <input type="radio"/> Autoimmunity |
| <input type="radio"/> Dizziness | <input type="radio"/> Pregnant | <input type="radio"/> Cholesterol |
| <input type="radio"/> Severe fatigue | <input type="radio"/> Bruise easily | <input type="radio"/> Blood pressure |
| <input type="radio"/> Night sweats | <input type="radio"/> Skin conditions | <input type="radio"/> HIV |
| <input type="radio"/> Epilepsy | <input type="radio"/> Thyroid | <input type="radio"/> Cancer |

Health history details

Surgeries

Medicines/Supplements

Alcohol consumption

Smoking

Excercise

Family history

TEST1

TEST2

TEST3

Current complaint

Please provide more information about your current condition.

What is the reason for your visit?

When did the problem begin?

What caused the problem?

What relieves your symptoms?

What aggravates your symptoms?

Lfgnlfnlfnhgfhlfgm;lhmfg;h

oifgjjhfgjjhfgjhfgjhfgjhfg

InInfnhnfgkngghfn

Yes

No

12

13

14

Yes

No

Hlkhhlkh

hhhljkjlj

hkhkjlj;lk;

Hello hader

hello into text

hello 1

Yes

No

hello 2

Private Health Insurance

If you have private health insurance that covers you for natural therapies, please provide your details below.

Health Fund

Fund name

Card Number

Number on card

Consent

I have to the best of my knowledge, provided all relevant information about my health and medical history and i give my full consent to treatment. I intend this consent to apply to all future treatments and understand that I must update my service provider with any changes that may occur in my medical history. I understand that a 50% cancellation fee may apply if I do not provide at least 24 hours notice.

☒ I consent to treatment

☒ I consent to receiving correspondence via SMS and/or email from my service provider

Name