

HOLISTIC HEALING ARTS CENTRE

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Reactivation Intake Form

Name: _____ Date: _____

Address: (if changed) _____ Email: _____

City: _____ Postal Code: _____ Telephone # _____

Occupation: _____ Employer: _____

Emergency Contact: _____
Name Telephone Number

How Can we help you? (what is your health problem?) _____

When did you 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?	Give date	What effect did it have on you?
_____	_____	_____
_____	_____	_____

What Supplements/ Natural Remedies are you taking now?

What has changed since your last visit? _____

Gotten Better? _____

Gotten Worse? _____

No difference? _____

(Please Indicate
Painful areas with an "X".)

