

Natural Solutions For You
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PATIENT CARE RECORD/CASE HISTORY FORM

Date _____

Name _____

Phone (Home) _____ (Cell) _____ (Work) _____

Occupation _____ No. hrs/day (week) _____

Address _____

Date of Birth _____ Weight _____ Height _____

Referred by _____

Main reason for coming _____

Date of last physical examination _____ Result _____

List all supplements (include dosage and brands): _____

Family Doctor's name _____

Daily consumption: Coffee _____ Tea _____ Alcohol _____ Smoke _____

Food _____ Appetite _____

Exercise _____ Sleep pattern _____

Epilepsy _____ Anemia _____ Diabetes _____ Bruise easily _____

Heart disease _____ BP _____ Headaches/Migraines _____

Earaches _____ Sinus / Allergies _____

No. Of colds/year _____ Chronic cough _____

Indigestion/Pain in abdomen _____ Constipation _____

Liver/Gall bladder/Kidney/Cystitis _____

Fainting/Dizziness _____ Leg cramps _____

Cysts _____ Sensitive skin _____ Rashes _____

Stiff/painful joints _____

Arthritis _____

Pain/tension in a back/neck _____

Surgery/Hospitalization _____

Accidents/Fractures _____

Menstruation/Pregnancies/I.U.D. _____

Other relevant information _____

Please list your major health concerns:

What relieves your condition?

What aggravates your condition?

SIGNATURE