VedicHealing

Patient History Form

Name:……Date:……

Date of Birth:…….....Height:……..Weight:……...

BMI:..……...

Email:……

Tel:……

Address:……...

……...

……...

Occupation:…….

Allergies:……..

……...

Dosha Analysis:……..

Current Symptoms:……

……...

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……...

List all Diagnoses:……..

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Medical and Surgical History:……...

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Current Medications:……..

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……...

Recent Labs:……...

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……...

Lifestyle / Daily Routine:

Wake up:……..

Breakfast:…….

Lunch:……...

Dinner:……..

Sleep:……

Exercise:……..

Alcohol use:…….

Tobacco use:……...

Family Life:……..

Recreation:……..

Social life:…….

Stress:……..

Energy:…….

Bowel Habits:……..

Menses:……

Travel:……..

Any other information you would like to share:……

……...

……...

……...

Please print this form, fill it to the best of your knowledge.
Fax it to 832-201-7711 or email it to admin@vedic-healing.com

www.vedic-healing.com

"Turning Ancient Wisdom into Personalized Wellness"