Confidential Patient Intake Form

Family history of any illness in family [Mother, Father, Brothers, Sisters, Grandfather (Maternal and Paternal), Grandmother (Maternal and Paternal), Uncles, Aunts: e.g.

Anaemia, Cancer, Diabetes, Anxiety, Depression, T. B. / Pleurisy,

Leprosy, Epilepsy Convulsion, Urticaria, Eczema, Bleeding tendency,

Asthma, Paralysis, Hypertension, Liver disease, Heart trouble, Kidney disease,

Obesity, Hemorrhoids, Arthritis, etc.

Past history of any illness, Medical procedures, surgeries, hospitalizations, accidents, trauma, etc

Date	Description

Chief complaint:

Aetiology / Cause	Location / Area / Part affected	Sensation / Feelings in the part affected	What makes it better	What makes it worse

Currently taking any Medications or Supplements:

Dated this ______ day of ______________, 201__.

_____________________________ _________________________

Patient Signature (Legal Guardian) Witness Signature

Name: _________________________ Name: _____________________

(Please print) (Please print)