

Cassis Holistic Care

BRT (Body Restoration Technique)

IF YOU NEED ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Social Security #: _____

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ AGE: _____ SEX: Male / Female

Height: _____ Weight: _____

ADDRESS: _____ CITY _____ STATE: _____

ZIP: _____ PHONE (W): _____ (H): _____

(C): _____ EMAIL ADDRESS: _____

YOU'RE OCCUPATION: _____

NAME OF SPOUSE OR NEAREST RELATIVE: _____

WHO REFERRED YOU? _____

Please list your five main physical complaints in order of importance.

1. _____
2. _____
3. _____
4. _____

What type of treatment are you currently receiving: _____

List any medication you are presently taking: _____

History of major illness / operation and treatment: _____

Known allergies: _____

Number of bowel movements per day: ____ **Are you a vegetarian?** Y / N

List any nutritional supplements you are taking: _____

Family illnesses:

Father: _____
Mother: _____
Grandmothers: _____
Grandfathers: _____
Brothers: _____
Sisters: _____

How much of the following do you consume per week:

Coffee: _____
Tea: _____
Alcohol: _____
Chocolate: _____
Cigarettes: _____
Laxatives: _____
Diet soda: _____
Regular soda: _____
Artificial sweeteners: _____

What foods do you crave: _____

What is your present weight: _____ **What is your ideal weight:** _____

What time of the day are you most tired: _____

Do you get depression, worry, lack of concentration, memory problems? Please explain: _____

If you're female, please explain any difficulties with your cycle or hormonal problems: _____

Please write down the major types of infections or illnesses you've had during your life, even as a child and roughly at what age: _____

Patient Signature: _____

Practitioners Notes: _____

