



ANCIENT HEALING TRADITIONS

Natural Solutions for Chronic Disease & Anti-Aging

CLIENT QUESTIONNAIRE FORM FOR HEALTH CONSULTATION

NAME: _____ DATE OF BIRTH: ____/____/____
(DAY) (MONTH) (YEAR)

ADDRESS: _____
(Apt. #) (Street) (City)

(State) (Country) (Zip Code)
PHONE NUMBER: (____) _____ OCCUPATION: _____

YOUR MEDICAL DOCTOR'S DIAGNOSIS (IF APPLICABLE): _____

DO YOU USE: CIGARETTES? _____ ALCOHOL? _____ DRUGS? _____

ARE YOU PREGNANT? _____ ARE YOU A VEGETARIAN? _____

SURGERIES/IMPLANTS/TRANSPLANTS? _____

CURRENT PRESCRIPTION MEDICATION: (Please List): _____

CURRENT SUPPLEMENTS: (Please List): _____

CHIEF COMPLAINT – SYMPTOMS: (Please list/describe): _____

OTHER COMPLAINT – SYMPTOMS: (Please list/describe): _____

NOTE: “I do not diagnose – I analyze. I do not prescribe – I suggest. For full diagnosis and treatment, please consult your medical practitioner.” – Dr. Danilla Severin, N.H.P.

You may fax this form to (604) 522-5410. If you do, *the following information is required:*
I authorize the fee of \$150.00 to be charged to my credit card: Visa _____ Master Card _____ (Please indicate)
Credit Card Number: _____ Expiry Date: _____
Signature: _____ Date: _____