

*CRAWFORD NATURAL HEALTH CENTER*  
*10231 FAIR OAKS BLVD, FAIR OAKS, CA 95628 - (916) 962-3101*  
[www.CrawfordNaturalHealthCenter.com](http://www.CrawfordNaturalHealthCenter.com)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Alternate Phone: (    ) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Please list all prescription and over-the-counter medications and supplements you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Are you currently being seen by (or recently been under the care of) another medical care provider?

Y / N. If yes, please provide the name and telephone # \_\_\_\_\_  
\_\_\_\_\_

For what medical condition(s)? \_\_\_\_\_  
\_\_\_\_\_

Chief complaint: \_\_\_\_\_ Location: \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Date of onset: \_\_\_\_\_ Mode of Onset: \_\_\_\_\_

Previous treatment?: \_\_\_\_\_

Getting better or getting worse? \_\_\_\_\_ Referred by: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_