Patient Case Record

Patient Name ______________________________________ Date____________

Address ________________________________City_______________________

State______________ Zip ___________________Telephone_________________

Cell#_________________ E-Mail _______________________________________

Age _________ Weight __________ Height ___________ Sex________________

Occupation ____________________ Marital Status _________________________

Emergency Contact Person / phone_______________________________________

History of illness and treatment ____

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Operations, Accidents, or Injuries ____

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Present illness or Complaints ____

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Current Medications ____

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Treatments, Recommendations, and Progress ________________________________

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Progress Report ____

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Herbal /Vitamin Supplementation ______________________________________

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Patient Signature ________________________________