

Annie Osborn, L.Ac.

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www.AnniesNaturalMedicine.com

Name: _____ Marital Status: _____ Number of Children: _____
Address: _____ Height: _____ Weight: _____ Birthdate: _____
City: _____ Occupation: _____
State: _____ ZIP: _____ Employer: _____
Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
Email: _____ Referred by: _____

Principal Concern: Check the primary areas of pain, discomfort or disorder.

Head____ Eyes____ Ears____ Nose____ Mouth____ Throat____
Heart____ Lungs____ Stomach____ Abdomen____ Bladder____ Lymph____
Neck____ Shoulder____ Arms____ Wrists____ Hands____ Fingers____
Fingernails____ Back____ Hips____ Legs____ Knees____ Calves____
Ankles____ Feet____ Toes____ Toenails____ Skin____ Weight____
Mentals____ Emotions____ Stress____ Nerves____ Memory____ Sleep____

Female Concerns: Check the primary areas of pain, discomfort or disorder.

Regularity____ Menses____ Preperiod____ Midcycle____ Postperiod____ Breast____
Vaginal____ Uterus____ Ovaries____ Desire____ Menopause____
Are you now or have you ever taken the Birth Control Pill? _____ If so, for how long? _____

History: Check any of the following conditions you presently have or have had.

Anemia____ Alcohol____ Allergies____ Asthma____ Arthritis____ Bronchitis____
Blood Pressure____ Candidiasis____ Cholesterol____ Colitis____ Cancer____
Colds____ Diabetes____ Dysentery____ Drug Abuse____ Epilepsy____ Flus____
Giardia____ Herpes____ Hypoglycemia____ Hepatitis____ Malaria____
Pneumonia____ Parasites____ Prostate____ Polio____ Rheumatic fever____
Strep____ Staph____ Skin disease____ Stones____ Thyroid____ Other____

Generalities: Check any of the conditions you are presently experiencing.

Fatigue____ Fever____ Tremors____ Impotency____ Chills____ Sweats____
Cravings____ Food intolerances____ Thirst____ Other____

Are you taking any medications? Please list: _____

Are you taking any nutritional supplements? Please list: _____

