



Natural Remedies
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IN:
DOB:

Established Client Form

Full Name: _____ Date: _____

Please list ALL medications and vitamins/supplements you are CURRENTLY taking:

Name of Rx Medications CURRENTLY Prescribed	Dose	Last Taken
1.		
2.		
3.		
4.		
5.		
Name of over-the-counter medications CURRENTLY taking	Dose	Last Taken
1.		
2.		
3.		
4.		
5.		
Name of Supplements/Vitamins CURRENTLY taking	Dose	Last Taken
1.		
2.		
3.		
4.		
5.		

List **CURRENT** medical conditions and concerns:

- _____
- _____
- _____
- _____

Name any allergies (medicines, environmental, food, etc.) you have, if any?

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Females Only:

What was the date of your last menstrual cycle? _____ Are you currently pregnant? **Y / N**

IN:
DOB:

Please note: If you have previously answered these questions regarding COVID-19, you do not need to complete this part again.

Have you tested positive for COVID-19? **Y / N** If so, when, what were your symptoms, and how severe were the symptoms?

Have you had a COVID-19 vaccine? **Y / N**

If yes, which one did you receive? (Please check one and write down the date you received each dose)

- Johnson & Johnson 1st Dose _____
- Moderna 1st Dose _____ 2nd Dose _____
- Pfizer 1st Dose _____ 2nd Dose _____
- Other _____ 1st Dose _____ 2nd Dose _____
- Booster Vaccine Name: _____ Date of Dose: _____

What would you like to achieve in today's consultation? _____

Please check any **additional** ZYTO scans you would like today.

- Today's Immunity \$175.00
- Lifestyle \$250.00
- Digestive \$150.00
- Wellness \$150.00
- Hormones \$100.00
- Foods for Wellness \$125.00
- Vitamins & Minerals \$100.00

By my signature below, I certify the information I provided on and in connection with this form is true and correct to the best of my knowledge.

Client's/Legal Guardian Signature

Date