Health History

First Name:	Last Name:		Gender:
Address:			
City:	State:	Zip:	
Phone:			
Email:			
Birthdate:	Place:		Age:
Occupation:		Marital Status:	
Emergency Contact:	Relationship:	Phone:	
Referred by:			

Reason for visit today: _____

When & how did this begin? _____

What makes better and worse? *Heat, ice, rest movement, etc…*

_____

How does this affect daily activities? *Work, sleep, appetite, etc…*

_____

What has been diagnosed by MD? _____

What treatment, if any, have you received for this condition?

_____

Significant Illnesses:

Cancer	Diabetes	Hepatitis	Heart Disease
High Blood Pressure	Seizures	Thyroid Disease	Venereal Disease
Allergies	Rheumatic Fever	Stroke	Other:

_____

_____

Your Birth History *Prolonged labor, forceps delivery, etc…* _____

_____

Health History

Surgeries *Please include age/date*

_____

_____

_____

Accidents/Injuries/Traumas/MVAs/etc. *Please include age/date*

_____

_____

_____

_____

Family Medical History:

Cancer	Diabetes	High Blood Pressure	Heart Disease
Stroke	Seizures	Arthritis	Asthma
Allergies		Other:	

_____

_____

Medications and supplements (including herbs & vitamins) you are currently taking:

_____

_____

_____

Do you have a regular exercise program?_____ Please describe: _____

_____

Describe your average daily diet:

_____

_____

List any habits (tobacco use, coffee/tea/cola, alcohol & recreational substances). How much & how often?

_____

_____

Do you believe you are or may be pregnant? _____