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Name: _____Age_____Date of Birth_____

Address:_____

Phone Number:_____ E-mail Address:_____Occupation:_____

Emergency Contact Name: _____ Phone Number:_____

Please specify any specific issues or problems you would like to address today:

_____
_____
_____
_____

When, where and by whom did you last receive medical health care? _____

Immunizations:

	Date		Date
Tetanus booster (every 10 yrs):		Pneumonia vaccine:	
Hepatitis A vaccine:		Flu vaccine:	
Hepatitis B vaccine:		Diptheria:	
Pertussis booster:		Other:	
Measles/Mumps/Rubella			

Medications - List all drugs, vitamins, herbs being taken at present with dosage.

Drug/Herb/Supplement	Dosage	Frequency	Duration

Are you allergic to any medications or other substances? ☐ Y ☐ N

Allergy:	Type of reaction:

Do you exercise: ☐ Y ☐ N

If so, what do you do, how much and how often?

_____
_____
_____

Describe a typical day's diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____

Health History

NOW	PAST	NEVER		NOW	PAST	NEVER	
☐	☐	☐	Allergies	☐	☐	☐	Eczema
☐	☐	☐	Anemia	☐	☐	☐	Emphysema
☐	☐	☐	Arthritis	☐	☐	☐	Headache
☐	☐	☐	Arthritis (osteo)	☐	☐	☐	Heart murmur
☐	☐	☐	Asthma (rheumatoid)	☐	☐	☐	High Blood Pressure
☐	☐	☐	Alcoholism	☐	☐	☐	Kidney Disease
☐	☐	☐	Bleeding	☐	☐	☐	Liver Disease
☐	☐	☐	Cancer	☐	☐	☐	Pneumonia
☐	☐	☐	Candida (yeast)	☐	☐	☐	Thyroid Disease
☐	☐	☐	Colitis	☐	☐	☐	Tuberculosis
☐	☐	☐	Drug abuse	☐	☐	☐	Venereal Disease
☐	☐	☐	Other (specify) _____				

☐ I don't know my family medical history

Hospitalizations/Surgeries

Type of illness or operation/procedure	Date	Hospital

Family History (Parents, Grandparents and Siblings)

YES	NO	Not sure		YES	NO	Not sure	
☐	☐	☐	Anemia	☐	☐	☐	Heart Disease
☐	☐	☐	Arthritis	☐	☐	☐	High Blood Pressure
☐	☐	☐	Asthma	☐	☐	☐	Mental Illness
☐	☐	☐	Blood disorder	☐	☐	☐	
☐	☐	☐	Cancer	☐	☐	☐	Seizures/Epilepsy
☐	☐	☐	Diabetes	☐	☐	☐	Sickle Cell
☐	☐	☐	Eczema	☐	☐	☐	Stroke
☐	☐	☐	Glaucoma	☐	☐	☐	Thyroid
☐	☐	☐	Gout	☐	☐	☐	Tuberculosis
☐	☐	☐	Hay Fever	☐	☐	☐	Other _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Co-habitate ☐ In a relationship

YES	NO		
☐	☐	Tobacco	If yes, how much per day? _____
☐	☐	Alcohol	If yes, how many drinks per week? _____
☐	☐	Recreational Drugs	If yes, which one(s) and how often? _____
☐	☐	Caffeinted drinks	If yes, how many per day? _____

Sleep

YES	NO		
☐	☐	Do you have trouble falling asleep?	If yes, what prevents you from falling asleep? _____
☐	☐	Do you have trouble staying asleep?	If yes, what prevents you from staying asleep? _____
☐	☐	Do you sleep straight through the night?	
☐	☐	Do you wake refreshed?	

Average hours of sleep per night: _____

Thank you for taking the time to fill this out. I look forward to helping you on your journey.