

HEALTH HISTORY

Last Name _____ First Name _____ Date _____

Address _____

Home Phone _____ Cell _____ DOB _____

Email Address _____ Age _____

Circle Marital Status: M S D W Occupation _____

Emergency Contact _____ Phone _____

Name of Physician _____ Phone _____

How did you hear about this clinic? _____

PLEASE MARK X IN THE BOXES BELOW IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS:

GENERAL CONDITIONS

- ADD/ADHD
- Anxiety/Depression
- Chronic Fatigue
- Motion Sickness
- Fibromyalgia
- Frequent Headaches
- Insomnia
- IBS (Irritable Bowel Syndrome)
- Migraines

RESPIRATORY CONDITIONS

- Asthma
- Chronic Cough
- Hay Fever
- Itchy/Watery Eyes
- Post Nasal Drip
- Runny Nose
- Sinus Problems/Headaches
- Sneezing
- Wheezing

DIGESTIVE

- Acid Reflux/GERD
- Abdominal Pain
- Bloating
- Constipation
- Diarrhea
- Gas
- Indigestion

SKIN

- Dermatitis
- Eczema
- Hives
- Rash
- Itching

Do you have false Teeth?

- Yes
- Upper Plate
- Lower Plate
- No

HEALTH HISTORY, con't.

Describe any other health / medical conditions that we should be aware of. (i.e., seizures, diabetes, pregnancy): _____

Please list any known or suspected allergies / sensitivities including any related symptoms:

FOODS:

SEASONAL:

OTHER:

Please list any prescription or over-the-counter medications you are taking currently:

Please read the following forms and initial to acknowledge that you have received a copy, read, understand, and agree to the terms and conditions listed therein:

New Patient Information Initials _____

Notice of Privacy Practices Initials _____

Clinic Policy and Procedures Initials _____

Signature: _____

Date: _____

(If under the age of 18, must be signed by parent/legal guardian)