Holistic Health Services
Brief Health History Questionnaire

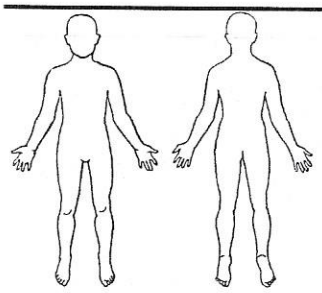
Name:		Sex:	DOB:
Street:	City:	State:	Zip:
Occupation:		Referred by:	
Phone:	**email:**		**Blood Type:**
Emergency Contact: (Name)		Phone:	
Primary Physician:		Phone Number:	
Have you ever had treatment from a Holistic or Natural Medicine practitioner?			
If yes explain:			

Health Issues you would like to address: _____

_____

Diagnosis by Physician? _____ Date Diagnosed? _____

Acute Symptoms Now:?: _____



Please circle or mark the chart to the left to indicate areas of pain or dysfunction

Comments: _____

_____

_____

_____

_____

Past Medical History (please include dates):

- ☐ Allergies _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Seizures _____
- ☐ Thyroid Disease _____
- ☐ Cancer _____
- ☐ Hepatitis _____
- ☐ Heart Disease _____
- ☐ Rheumatic Fever _____
- ☐ Venereal Disease _____
- ☐ Other Significant Illnesses (describe) _____
- ☐ Accidents of Significant Trauma _____

Family Medical History:

- ☐ Allergies
- ☐ Cancer
- ☐ Seizures
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Other _____

Lifestyle:

Do you follow a regular exercise program? _____ If so, please describe: _____

Please check any of the following habits that apply. Indicate how much and how often you consume them:

☐ Cigarettes ☐ Coffee, Tea or Cola ☐ Alcoholic Beverages ☐ Salt ☐ Sugar ☐ Drugs ☐ Other

_____

Medications taken within the last two months (vitamins, herbs, etc.) _____

_____

_____

_____

_____

Signature: _____ Date: _____