

# HEALTH HISTORY FORM

Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: (Home) \_\_\_\_\_ Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Full or Part Time: \_\_\_\_\_  
Employer: \_\_\_\_\_

Email address: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

When, where and from whom did you last receive medical or health care? \_\_\_\_\_

What are your most important health concerns?

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Which of the above problems are of most immediate concern? \_\_\_\_\_

List of current prescription medications

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Any history of allergic reaction to medications?

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List of current vitamins and supplements

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List of any other current medical or health treatments (e.g. acupuncture, massage, dental, chiropractic)

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Height \_\_\_\_\_ Weight \_\_\_\_\_