Health & Wellness History

Name: ____ Date: ________________
Street Address: ____
City: ______________________State: ______________Zip: __________________
Home Phone: ________________________ Cell Phone: ______________________
Email Address: ____
Sex: M F Age: _____________Birth date: ___________________________
Marital Status: Single Married Widowed Separated Divorced
Employer: __________________________________ Occupation: ______________
Street Address: ____
City: ______________________State: ______________Zip: __________________
Work Phone: ___________________________ Work Status: Full time Part time
Purpose of Today's Visit: ____
____
What are Your Top 3 Health Concerns: ____________________________________
____
Previous Weight Loss Programs: ____
Successes: ________________________Failures: ___________________________
Currently Care Under? M.D. ____________________ D.C. ___________________
Other: ____
Recent Physical Exams: ___________________________Date: __________________
Lab Work: ________________________Where/When: _______________________
X-Rays, MRI, CT:__________________ Where/When: _______________________
Stress Test: ______________________ Where/When: _______________________
Other: ____
Vitamins/Minerals Currently Taking: _______________________________________
Herbs: ____
Medical Prescriptions: ____
Over the Counter Medications: ____
Known Allergies – Sensitivities: ____
Family History: ____
Previous Illnesses: ____
Surgeries: ____
Accidents: ____

Your signature below indicates that you understand that you are solely responsible for any treatment rendered in this office. All services rendered to you are charged directly to you, and you are personally responsible for payment. This office does not accept insurance of any kind. (Please advise us immediately if you are a Medicare patient, as we do not treat Medicare patients for services covered by Medicare.)

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit. Your signature also indicates that you authorize the staff to perform any necessary services needed during diagnosis and treatment, and that you understand the above information and guarantee this form was completed correctly to the best of your knowledge and understand it is your responsibility to inform this office of any changes to the information you have provided.

Signature: ____________________________________ Date: _________________