Healthy by Nature Family Wellness Clinic, LLC

Health History

Today's Date_____

Name_____ DOB_____ Age_____ Sex_____

Height_____ Weight_____ Marital Status: ___ Single ___ Married ___ Widow(er) ___ Partner

Are you pregnant? No Yes Are you nursing? No Yes

Health issues you would like to address:

_____

_____

What kind of work up have you had (if any) for these issues and what were the results?

_____

_____

What types of therapies have you tried?

__ Primary Care Work Up ___ Chiropractic ___Diet Changes ___Acupuncture ___Homeopathy

___Vitamins/Minerals/Herbals ___ Prescription Medications ___ Physical Therapy (or other therapies)

_____

Allergies & Reactions_____

Prescription Medications	Nutritional or Herbal Supplements

Past and Current Health Diagnoses and/or Major Past Illnesses or Injuries:

Surgical History and Approximate Dates:

Any unintentional weight gain or loss of greater than 10 lbs. in the past 6 months? No Yes Amount_____

Past or current tobacco use? No Yes Type of product: _____ Use per day_____

Are you on any special diet(s)?_____

Are you experiencing a lot of stress? No Yes Type of stress_____

Do you have trouble falling asleep? No Yes Staying asleep? No Yes Poor sleep quality? No Yes