PATIENT INFORMATION

Whole Family
WELLNESS

PERSONAL INFORMATION

Full Name

Date of Birth	Gender ☐ Male ☐ Female
Address	
Phone Number	E-Mail
Parents/Guardians	
Status ☐ Single ☐ Married ☐ Divorce ☐ Others	

Occupation

Please tell us the reason for your visit today:

EMERGENCY CONTACT DETAILS

Contact Name	Home Number
Relationship	Mobile Number

INSURANCE

Provider	Membership Type
Membership Number	Payment Type

Signature: _____

Date: _____

Print name: _____

MEDICAL HISTORY

Whole Family
WELLNESS

CURRENT HEALTH

Please check ALL conditions you currently have:

- ☐ Headaches
- ☐ Cancer
- ☐ Diabetes
- ☐ Blood clots
- ☐ Allergies _____
- ☐ Other _____

_____

- ☐ Arthritis/tendonitis
- ☐ Abnormal skin condition
- ☐ High/low blood pressure
- ☐ Fibromyalgia
- ☐ Neck/back injury
- ☐ Numbness
- ☐ Varicose veins
- ☐ Recent injury
- ☐ Nursing / Pregnant
- ☐ Depression
- ☐ Fatigue

MEDICAL HISTORY

Do you have a history of heart/circulation problems?	☐ Yes	☐ No
Do you have a history of blot clots?	☐ Yes	☐ No
Do you have a high/low blood pressure?	☐ Yes	☐ No
Do you have a history of high cholesterol?	☐ Yes	☐ No
Do you have a history of STD/HIV?	☐ Yes	☐ No
Have you had any surgeries?	☐ Yes	☐ No

If yes, please explain:

MEDICATION & SUPPLEMENTS

Please list any medications and/or supplements you are currently taking and the dosage: