Health History and Questionnaire

Please print clearly:

Name _____

Address _____

Phone _____ Occupation _____

Date of Birth _____ Age _____

Email _____

Have you ever had any energy work before? (circle) Y N

If so what? _____

What is the present condition of your Health? _____

_____

When did you last see your Doctor? _____

For what reason? _____

Any possibility of pregnancy? (circle) Y N

Are you currently participating in any other therapies besides conventional medicine or chiropractics? _____

Are you taking any medications? (circle) Y N

If so, list them. _____

_____

Do you have any chronic health conditions? (circle) Y N

If so, explain. _____

_____

_____

_____

Please check any medical conditions I should be aware of. Also include any recent rashes, bruises, bumps, breaks, sprains, fractures, or illnesses. A partial list follows but is not meant to be all-inclusive.

- ❍ ADD
- ❍ Addiction(s)
- ❍ ADHD
- ❍ Aids
- ❍ Autism
- ❍ Allergies (List below)
- ❍ Amalgam (Silver Fillings)
- ❍ Asthma
- ❍ Cancer/Malignancy
- ❍ Chronic Pain
- ❍ Contacts
- ❍ Dentures
- ❍ Depression
- ❍ Epilepsy
- ❍ Fluid Retention
- ❍ Food Sensitivities
- ❍ Fractures/Breaks
- ❍ Headaches
- ❍ Heart disease
- ❍ Herpes
- ❍ Mental Illness
- ❍ Learning Disorders
- ❍ Migraines
- ❍ PMS/Troublesome cycles
- ❍ Reproductive issues or concerns
- ❍ Root Canals
- ❍ Surgeries
- ❍ Tick bites/ Spider Bites
- ❍ Other: _____

Explain any of the above *and* add anything you feel is of importance which has not been addressed above: _____

_____

_____

_____

_____

_____

_____

Name/Phone # of primary care physician _____

_____

Signature (Guardian if under age 18) Date

Were you referred by anyone? If so, who _____