Confidential Health History Form

Name: _____ Birth Date: _____

Street Address: _____ Home phone: _____

City/State/Zip: _____ Work (cell): _____

Email address: _____ Today's Date: _____

Occupation: _____ Physician: _____

Emergency Contact: _____ Emergency Telephone: _____

Who referred you to AcuCare Clinic? _____

==========

What is the primary reason for your visit today?

What other conditions would you like to have addressed?

Are you currently under the care of a physician, physical therapist, dermatologist or any other health care practitioner? If yes, please describe.

Are you currently taking any medications? If yes, please list.

Are you currently taking any supplements? If yes, what are they?

What is the health of your family?

Mother: Father: Siblings:

Are there any hereditary illnesses that run in your family?

Did you have any unusual / uncommon illnesses as a child or any major accidents / surgeries?

Have you been bothered by any of the following conditions in the past year?

__ Allergies
__ Varicose Veins
__ Diabetes / Hypoglycemia
__ Cancer
__ Menstrual Problems
__ Chest Pain / Heart Disease
__ Unusual or recurrent headaches
__ Depression / Anxiety
__ High Blood Pressure
__ STD's
__ Drug / alcohol abuse
__ Bleeding Disorder
__ Seizures
__ Fainting
__ Recurrent infections
__ Hypo- / Hyper- thyroid
__ Stroke
__ Major shock or loss
__ Hepatitis
__ High or sustained fever
__ Any other major condition
Explain:

May we contact you concerning your treatment at AcuCare Clinic?

How would you like to be contacted? __ Phone __ Letter __ Email

Patient Signature _____ Date _____

(Parent / Guardian / Other) _____ Date _____