Health History

Name _____Date of Birth _____Today's Date _____

Address _____ City _____ State/Zip _____

Phone Number(s) _____ Email _____

Emergency Contact _____ Phone Number _____

Primary reason(s) for today's visit _____

_____

Medical conditions _____

_____

Mental/Emotional conditions _____

_____

Past surgeries _____

_____

Medications _____

_____

Primary care provider _____ Phone number _____

Other complementary care providers _____

Is there any other information you would like me to know about you, your health, or the care you would like to receive?

_____