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GENERAL HEALTH & WELLNESS HISTORY

Name: _____ Date: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____
Email Address: _____
Sex: M F Age: _____ Date of Birth: _____
Marital Status: ___Single ___Married ___Widowed ___Separated ___Divorced
Employer: _____ Occupation: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____ Work Status: ___Full time ___Part time
What are your top three health concerns: _____
_____
_____
_____

DESIRED WEIGHT: (Significantly Below, Below, Good, Over, Significantly Over)
Struggled Weight Patterns: (Most of life, last 10 years, Last 5 years, Within last year)
Previous Weight Loss Programs: _____
Successes: _____ Failures: _____
Moderate to significant Mental Health or Relational Stresses (Yes or No)
Current Care Under? M.D. _____ D.C. _____
Other: _____
Recent Physical Exams: _____ Date: _____
Lab Work: _____ Where: _____
X-Rays, MRI, CT: _____ Where: _____
Stress Test: _____ Where: _____
Other: _____ Where: _____
Vitamins/Minerals Taking: _____
Herbs: _____
Medical Prescriptions: _____
Over the Counter Medications: _____
Known Allergies -- Sensitivities: _____
Family History: _____
_____
Previous Illnesses: _____
Surgeries: _____
Accidents: _____

_____ _____
Patient Signature Date