

TO BE COMPLETED BY THE CLIENT:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Medical Doctor: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_ Doctor's Fax #: \_\_\_\_\_

**Current Medications:** (Please include both prescription and over-the-counter medications)

Medication Name	Amount/Dose	For What?	Name of Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on a special diet \_\_\_\_\_ What? \_\_\_\_\_

**Allergies:**

**Reactions:**

Drug \_\_\_\_\_

Food \_\_\_\_\_

**Brief Medical History:** Please check if you have (or had in the past) a problem(s) with the following:

Heart _____	Sinus _____	Blood Pressure _____	Drugs _____
Cancer _____	Digestion _____	Ear/hearing _____	Alcohol _____
Diabetes _____	Elimination _____	Eyes/Vision _____	Surgery _____
Skin _____	Headaches _____	Respiratory Disease _____	Stroke _____
Seizures _____	Kidney Disease _____		
Height: _____	Weight: _____	Weight Gain or Loss _____	

Do you use tobacco products? Yes  No

Please comment here on any problems checked above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Hospitalizations:** Have you ever been hospitalized? Yes  No

For What? \_\_\_\_\_ For What? \_\_\_\_\_ For What? \_\_\_\_\_

Date(s): \_\_\_\_\_ Date(s): \_\_\_\_\_ Date(s): \_\_\_\_\_

Who can we notify in case of an emergency? Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Information provided by: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY HEALTH CARE TEAM:**

Health Care Team Recommendations for: \_\_\_\_\_

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Medication received from other sources:

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Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_