Julie Rake
HEALING

Patient Information								
Name	DOB	Gender:		M		F		Other
Address							Phone:	
Emergency Contact								
Name:	Relationship:						Phone:	
Insurance Information								
Insurance Provider							Policy number	

Personal history *(check all that apply)*

☐ No known medical conditions	☐ Heart Attack / Heart Disease
☐ Allergies (Drug, Food, Environmental)	☐ High Blood Pressure (Hypertension)
☐ Anemia	☐ High Cholesterol
☐ Anxiety	☐ HIV/AIDS
☐ Arthritis	☐ Kidney Disease / Kidney Stones
☐ Asthma	☐ Liver Disease / Hepatitis
☐ Blood transfusion	☐ Migraines
☐ Cancer (Specify: _____)	☐ Osteoporosis
☐ Congestive heart failure	☐ Stroke
☐ COPD / Emphysema	☐ Substance Abuse (Alcohol / Drugs)
☐ Depression	☐ Thyroid Disease (Hypo / Hyper)\
☐ Diabetes (Type 1 / Type 2)	☐ Tuberculosis
☐ Epilepsy / Seizures	☐ Ulcers
☐ GERD (Acid Reflux)	
☐ Glaucoma	
☐ Gout	

Other medical issues:

Treatments/Medications

Name(s)	Dosage(s)	Frequency	Purpose	Note(s)

Surgeries/Procedures:
☐ Heart surgery ☐ Cholecystectomy ☐ Appendectomy, ☐ C-section ☐ Hysterectomy ☐ Bladder ☐Colonoscopy ☐EGD ☐ Joint ☐Other __

Allergies

Family history *(check all that apply)*

☐ No known family history of medical conditions ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Thyroid Disease ☐ Kidney Disease ☐ Mental Health Conditions (Depression, Anxiety, etc.) ☐ Autoimmune Diseases ☐ Other: _____

Social history

Factor	**Check one**	**Most recent date** *(if applicable)*
Tobacco Use	☐ Cigarettes ☐ Vaping ☐ Tobacco	
Alcohol Use	☐ Occasional ☐ Moderate ☐ Heavy	
Recreational Drugs	☐ No ☐ Yes (Specify)	
Caffeine	[ ] Times per week	
Exercise Routine	[ ] Times per week	
Sleep	[ ] Hours a night	

Any Social Detriments to Health? ☐ No ☐ Yes *(describe)* _____

Occupation:	Living Situation: ☐ With roommates ☐ With S/O ☐ With family ☐ Other: _____

Review of Systems *(Check any symptoms that you are experiencing)*

General	*EENT*	*Cardiovascular*
☐ Fatigue ☐ Fever or chills ☐ Unexplained weight loss/gain	☐ Vision changes (blurry, double vision) ☐ Hearing loss or ringing ☐ Sore throat / Hoarseness	☐ Chest pain or tightness ☐ Palpitations (fast or irregular heartbeat) ☐ Swelling in legs or feet
Respiratory	*Gastrointestinal*	*Genitourinary*
☐ Shortness of breath ☐ Chronic cough ☐ Wheezing	☐ Abdominal pain ☐ Nausea or vomiting ☐ Diarrhea or constipation	☐ Incontinence ☐ Burning ☐ Urgency ☐ Frequency ☐ Blood in urine
Musculoskeletal	*Psychiatric*	*Neurological*
☐ Joint pain or stiffness ☐ Muscle weakness ☐ Back pain	☐ Depression or feeling down ☐ Anxiety or panic attacks ☐ Sleep disturbances (insomnia, nightmares)	☐ Headaches or migraines ☐ Dizziness or lightheadedness ☐ Numbness or tingling

Patient Signature: Date: