Shalem Healing

Medical History Form

Today's Date: ____

Patient Name: ____

Preferred Name:____

Date of Birth: ____

Current Occupation: ____

Current Tobacco user:

If **yes**, please fill out below:	If **no**, please fill out below:
How many packs day: ____ How many years:__________	No: _______________ quit date:____________ how many packs per day: ______

Any Alcohol use: No _______

If **yes,** please fill out below:
# of beers/week_______ # of liquor beverages/week______ # of wine/week_________

Any use of marijuana or other recreation drugs? Yes:___ No:___

If yes, please be specific: ____

Major Events or Surgeries: please list below:

Name of Surgery or major event:	Year it occurred:

Do you have OR have you ever had: Please check one.

- Anxiety/Depression/bipolar Yes: __ No: __ if yes Specifics: ________________________
- Arthritis. Yes: __ No: __ if yes Specifics: ________________________
- Asthma Yes: __ No: __ if yes Specifics: ________________________
- Bleeding Disorders Yes: __ No: __ if yes Specifics: ________________________
- Blood Clots Yes: __ No: __ if yes Specifics: ________________________
- GI/Intestinal Problems. Yes: __ No: __ if yes Specifics: ________________________
- Diabetes. Yes: __ No: __ if yes Specifics: ________________________
- Glaucoma/eye problems. Yes: __ No: __ if yes Specifics: ________________________
- Hearing problems. Yes: __ No: __ if yes Specifics: ________________________
- Heart attack/Disease. Yes: __ No: __ if yes Specifics: ________________________
- High Blood Pressure. Yes: __ No: __ if yes Specifics: ________________________
- High Cholesterol Yes: __ No: __ if yes Specifics: ________________________
- HIV/AIDS. Yes: __ No: __ if yes Specifics: ________________________
- STI's Yes: __ No: __ if yes Specifics: ________________________
- Kidney Disease. Yes: __ No: __ if yes Specifics: ________________________
- Liver Disease. Yes: __ No: __ if yes Specifics: ________________________
- Lung Disease. Yes: __ No: __ if yes Specifics: ________________________
- Mental Health problems. Yes: __ No: __ if yes Specifics: ________________________
- Seizures Disorder Yes: __ No: __ if yes Specifics: ________________________
- Skin Problems. Yes: __ No: __ if yes Specifics: ________________________
- Stroke. Yes: __ No: __ if yes Specifics: ________________________
- Thyroid Disorders. Yes: __ No: __ if yes Specifics: ________________________
- Hepatitis Yes: __ No: __ if yes Specifics: ________________________
- Cancer Yes: __ No: __ if yes Specifics: ________________________
- Implants/medical devices Yes: __ No: __ if yes Specifics: ________________________
- Other. if yes Specifics: ________________________
- Other. if yes Specifics: ________________________

Are you allergic to any of the following medications: Please list foods or environmental allergies as well.

- Aspirin Yes: __ No: __ if yes reaction:_______________
- Penicillin Yes: __ No: __ if yes reaction:_______________
- Codeine Yes: __ No: __ if yes reaction:_______________
- Latex Yes: __ No: __ if yes reaction:_______________
- Sulfa Drugs Yes: __ No: __ if yes reaction:_______________
- Others Type:________ reaction:____________________
- Others Type:________ reaction:____________________
- Others Type:________ reaction:____________________
- Others Type:________ reaction:____________________
- Others Type:________ reaction:____________________
- Others Type:________ reaction:____________________
- Others Type:________ reaction:____________________

Medications: Please fill out below:

Medication Name:	Dose:	Directions & how often:

Supplements: Please fill out below:

Supplement/Vitamin name:	Dose:	Directions & how often:

Nutrition history:

Any special diet such as Kosher, Vegetarian, Vegan etc.… **please list here**:___________________

Then please list what you typically have for the following:

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

Beverages:____

Family Health History:

Please fill out anything that would run on either side of your family such as high blood pressure, asthma, heart disease etc…

Mother:____

Father:____

Siblings:____

Some examples would be:

• Anxiety/Depression/ bipolar • Arthritis • Asthma • Bleeding Disorders • Blood Clots • GI/Intestinal Problems • Diabetes • Glaucoma/eye problems	• Hearing problems • Heart attack/Disease • High Blood Pressure • High Cholesterol • HIV/AIDS • STI's • Kidney Disease • Liver Disease • Lung Disease • Mental Health problems	• Seizures Disorder • Skin Problems • Stroke • Thyroid Disorders • Hepatitis • Cancer • Implants/medical devices

Do you feel safe at home? Yes: ____ No: ____

Any past or current thoughts about harming yourself or others? Yes: ____ No: ____

Any plans to harm yourself or others? Yes: ____ No: ____

Do you wish to speak with someone about your home environment? Yes: ____ No: ____

Do you wish to have any assistance with any of the above? Yes: ____ No: ____

Patient signature:____

Date: ____