FARMA THERAPY

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HEALTH HISTORY

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

How did you hear about us: _____

MMCC ID #:_____ - _____ - _____ - _____

Patient Signature / Date: _____

MEDICAL HISTORY

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Cancer
- ☐ Chronic pain /location
- ☐ Depression
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Migraines
- ☐ MS
- ☐ PTSD
- ☐ Persistent muscle spasms
- ☐ Nausea
- ☐ Severe pain
- ☐ Seizures
- ☐ Significant weight loss
- ☐ Other, please specify

SURGERIES / YEAR:

_____

Are you currently receiving care from any other doctors, chiropractors, or other health care Professionals? Please write the provider's name:

_____

_____

When was your last doctor's visit? _____

MEDICATIONS:

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking

Medication / Dose:

_____

_____

_____

ALLERGIES: _____

Do you smoke cigarettes or use any tobacco products?

Yes:- how many / day / how many years _____ No_____Quit_____

Do you drink alcohol?

Yes:- how many drinks / day_____ No_____Occasionally_____ Quit_____

Are you employed?/ If yes, what kind of work do you do?

_____

WOMEN ONLY: Are you pregnant or breastfeeding?