JUDITH BROOKS, L.Ac. LMBT
NC Lic. # 133, 1313
919-260-1430

PATIENT MEDICAL HISTORY FORM

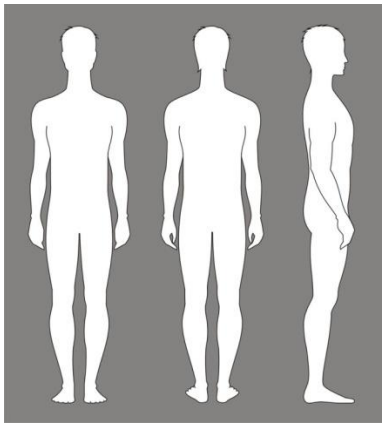
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ _____WORK PHONE: _____
CELL PHONE: _____ _____EMAIL: _____
BIRTHDATE: ___/___/___ SINGLE MARRIED PARTNERED OTHER
OCCUPATION: _____ EMPLOYER: _____
EMERGENCY CONTACT: _____ PHONE: _____

CURRENT HEALTH

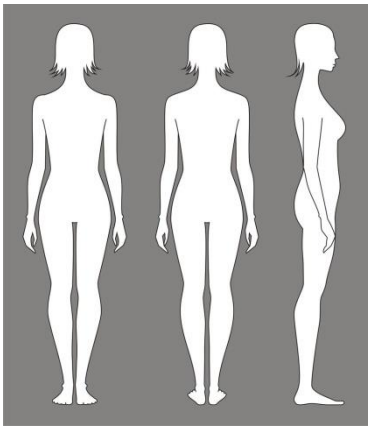
Reason for today's visit (check all that apply):

___ Relaxation/stress relief
___ Recovery from injury or illness
___ Specific muscular pain
___ General muscle soreness or fatigue
___ Pregnancy/ Post-partum
___ Body-mind awareness
___ Other: _____
_____

Main health problems: _____
_____
Have you ever been given a diagnosis for this problem (s)? _____
What was it? _____
When did it start? _____
What treatments have you tried? _____
_____
Please circle below the areas of physical discomfort in your body:



MALE
front back side



FEMALE
front back side

NAME: _____

Check any of the following that apply to your current health:

___ Blood clots
___ High/low blood pressure
___ Diabetes
___ Cancer
___ Infections
___ Heart conditions
___ Arthritis
___Acute injury
___ Cold/Flu
___ Pregnancy under 13 weeks
___ Other: _____
_____

Current medications (including over-the-counter and herbal remedies and vitamins):

_____
_____
_____

PREVIOUS HISTORY

List in chronological order, give dates or ages, and treatment received:

Surgeries:

_____
_____
_____

Accidents or Hospitalizations:

_____
_____
_____

Major illnesses and diseases:

_____
_____
_____

Have you ever had Hepatitis (A, B, Non-A or Non-B)? _____
Do you smoke (how much?)_____
Use alcohol (how much?) _____
Drink coffee (how many cups per day?) _____

Family Medical Problems (Father, Mother, Siblings, Other)?

_____
_____