New Patient History– Nancy Imig Smith, L.Ac., Dipl. Ac.

Name: ______________________________________Date of Birth:______________ Ht:____ Wt: :_____ Date: ____________

Street:____ City:_____________________ State:______ Zip:_________

Phone #'s: Cell: __________________ Home: ____________________ Work: ______________ Referred By: _________________

Email Address:____ Marital Status:__________ # of Children: ______

Emergency Contact Name:_____________________________ Emergency Contact Phone: _______________________

Physician's Name:_________________________________ Physician's Phone: ________________________

What is your main health concern that has brought you to the Healing in Progress clinic?
1. Date of Onset:

Additional concerns you'd like to address:
2. Date of Onset:
3. Date of Onset:

What treatments have you received for these conditions?
____
____

Please list any food or drug allergies:
____

Please list any surgeries/hospitalizations and dates:
____
____

Your Past Medical History (check any you currently have or have had in the past):
__ AIDS/HIV __ Cancer __ Heart Disease __ Pacemaker __ Stroke
__ Alcoholism __ Chicken Pox __ Hepatitis __ Pleurisy __ Thyroid disorders
__ Allergies __ Diabetes __ Herpes __ Pneumonia __ Tuberculosis
__ Appendicitis __ Emphysema __ High blood pressure __ Polio __ Typhoid fever
__ Arteriosclerosis __ Epilepsy __ Measles __ Rheumatic fever __ Ulcers
__ Asthma __ Goiter __ Multiple Sclerosis __ Scarlet fever __ Venereal disease
__ Birth Trauma (own birth) __ Gout __ Mumps __ Seizures __ Whooping cough
Other____

Do you typically eat at least 3 meals per day? Y N If not, how many? __________________

Exercise Routine: ____

How many hours per night do you sleep?___ Do you wake rested? Y N Nighttime Urination:_________

Occupation: ________________________ Hours per week: ________ Do you enjoy work? Y N

Do you smoke cigarettes? Y N If yes, for how long? __________ How much? ________

Do you consume alcohol? Y N If yes, what kind? _____________ How often? ________

Do you use recreational drugs? Y N If yes, what kind? __________ How often? ________

Do you drink caffeine? Y N If yes, what kind? ______________ How much? ________

Have you experienced any major traumas? Y N Explain: ____

How much water do you drink per day? ____________ How do you relieve stress? ____________________________________

Women: Date of last menstrual cycle:_________________________________ Are you currently pregnant? Yes No

Date of last Pap smear: _________________________. Date of last Mammogram_________________________