Medical History Questionnaire

LUNA ROCK
Wellness & Healing

Name:

Date of birth (day/month/year):

Address home:

Phone:

Work address:

Phone:

Occupation:

Who referred you?:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name:

Relationship:

Phone:

Name of family Doctor:

Address:

Phone:

Name of medical specialist:

Area of speciality:

Address:

Phone:

The following information is required to enable us to provide you with the best possible care. All information is strictly private, and is protected by practitioner-patient confidentiality. The practitioner will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

Yes No Not Sure/Maybe

2. When was your last medical check-up?

3. Has there been any change to your general health in the past year? If yes, please explain.

Yes No Not Sure/Maybe

4. Re you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

Yes No Not Sure/Maybe

Signature: Date: