NEW BEGINNINGS HEALTH HISTORY FORM

PERSONAL INFORMATION Date:_____

First Name: _____Last Name: _____Date of Birth: _____/_____/_____ Age: ____

MEDICAL INFORMATION

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy**: _____

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter:

MEDICATION	DOSAGE	ROUTE	FREQUENCY

If you have or had any of the following, please check:

- o ADD/ADHD Anemia
- o Allergies/Hay Fever
- o Asthma
- o Arthritis
- o Anxiety/Depression
- o Alcoholism
- o Blood Clots
- o Cancer, Type/s
- o Type 1 or 2 diabetes
- o Fractures
- o Gynecological Disease
- o High Blood Pressure
- o High Cholesterol
- o Heart Attack
- o Kidney Disease
- o Liver Disease
- o Neurological Disease
- o Obsessive Compulsive Disorder
- o Osteopenia/Osteoporosis
- o Post Traumatic stress disorder
- o Respiratory Disease
- o Schizophrenia
- o Skin Disease
- o Social anxiety disorder
- o Stomach/Colon Disease
- o Stroke
- o Seizure Disorder
- o Thyroid Disorder
- o Sexually Transmitted Disease
- o Other:_____

Please list any SURGERIES you have had and include the month/year:_____

_____

TABACCO USE AND HISTORY

Tobacco Use: Do you smoke? If so, how many cigarettes/cigars per day: _____ No. of years smoking:_____
Do you chew tobacco? Have you thought about quitting? Have you quit before? How long?
Do you want resources or help quitting tabacco related products?

ALCOHOL AND DRUG USE AND HISTORY

Alcohol Use: Do you drink alcohol? If so, what type? How many in 1 week?
Drug Use: Any history of illegal drug use? If so, what type/s? When?

DIET AND PHYSCIAL ACTIVITY

Do you exercise? What activities do you do, and how often in 1 week?_____
Are you on any special diet? If so, what? _____
Do you consume any caffeinated products? _____ If so, what and how much per day? _____

BEHAVIORAL HISTORY

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities?	Yes	No	Sometimes	Frequently
Do you have thoughts of suicide?	Yes	No	Sometimes	Frequently
Do you have thoughts of hurting others?	Yes	No	Sometimes	Frequently

Patient Signature: _____ Date: _____