Partners in Health Healing Arts Center
Patient History Form

Name: _____ Date of Birth: _____

Current Medical Problems: (I.E. Asthma, High Blood Pressure, Diabetes, Ulcers, etc)

Past Medical Problems: (Problems that have since been resolved)

Hospitalizations:

Surgeries:

Family History: (Cancer, Heart Disease, Diabetes, etc)

Have you had problems with depression or mental illness? Yes ____ No ____
Have you ever tried to commit suicide? Yes ____ No ____
Are you on any prescription medicines, vitamins, or supplements? (list name, strength, dose)

Are you allergic to any medications?

Did you/ Do you smoke tobacco? Yes ____ No ____ How many packs per day? _____
Do you drink alcohol? Yes ____ No ____
If so, how many drinks per: Day_____Week_____Month_____
Did you/ Do you use illegal drugs? Yes ____ No ____
If so, which drugs and how often?

What do you spend the majority of your day doing? (i.e. work/school/family)

What are your long term goals and dreams?

Are you happy? Yes ____ No ____ Sometimes ____
What is "the key to life"?

Are you in a relationship? Yes ____ No ____
Why are you here today?