DR. TODD FRISCH
SHAPE ReClaimed Founder/Developer
510 Baxter Road, Suite 6
Chesterfield, MO 63017
636-484-8444

CONFIDENTIAL HEALTH HISTORY

TODAY'S DATE_____

Name:_____**Birthdate**: _____/_____/_____ **Home #**_____
Please Print Clearly MO Day Year **Cell #** _____

Address:_____ **Status** S M W D
STREET CITY STATE ZIP

Responsible Party:_____**Social Security #**_____

Occupation:_____**Employer**:_____

How will you be paying? Cash ☐ Check ☐ Credit Card ☐ **Work Phone**_____

Primary Insurance Company_____**ID#**_____

Name of Insured: _____ **Date of Birth**:_____

In Case of an emergency contact: _____Phone:_____

AGREEMENT

I HEREBY ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED ME. I UNDERSTAND THAT IN THE EVENT IT BECOMES NECESSARY TO EMPLOY AN ATTORNEY/COLLECTION AGENCY TO COLLECT ANY OUTSTANDING MONIES DUE, I WILL BE RESPONSIBLE FOR ALL FEES INCURRED BY DR. TODD FRISCH.

DATE_____ **SIGNATURE** _____

Major complaints and symptoms. When did you first notice the problem? Please be as specific as possible.

_____

_____

_____

Please briefly list (with dates) any serious auto accidents, injuries, hospitalizations, surgeries:

_____

_____

_____

Medications including vitamins currently taken:

_____

_____

Allergies (drugs, foods, airborne pollens, etc._____

_____

PLEASE COMPLETE THE REVERSE SIDE

Dietary preferences/restrictions: _____

Routine physical exercise: Type_____ Times per week:_____

Tobacco	**Amount**	**Caffeine**	**Amount**	**Alcohol**	**Amount**
☐ Current/Pks per day	_____	☐ Coffee	_____	☐ Wine	_____
☐ Previous/Pks per day	_____	☐ Tea	_____	☐ Beer	_____
How long since quitting?	_____	☐ Soda	_____	☐ Hard Liquor	_____

Toxic exposure at home or work: (toxic chemicals, fumes, etc.)
☐ Yes ☐ No If yes, describe._____

DAILY LIVING STRESSES Please complete with honesty, as this will allow us to understand your wellness or lack of.
Circle Yes or No

Do you struggle with losing excess weight?	Yes	No
Have you tried multiple weight loss programs?	Yes	No

Job Description:_____

Is your job rewarding?	Yes	No
Do you get along with the people you work with?	Yes	No
Do you feel stressed with your responsibilities?	Yes	No
Are you satisfied with life?	Yes	No
Do you have feelings of loneliness?	Yes	No
Are you happy with yourself?	Yes	No
Are you discouraged about the future?	Yes	No
Do you have feelings of joy?	Yes	No
Do you have feelings of guilt?	Yes	No
Do you have concerns with relationships?		
Spouse/Partner:	Yes	No
Parent:	Yes	No
Child:	Yes	No
Sibling:	Yes	No
Friend:	Yes	No
Have you suffered a recent death of a loved one?	Yes	No
Are you responsible for a seriously ill loved one?	Yes	No

WOMEN ONLY
Are you pregnant? ☐ Yes ☐ No Date of last menstrual cycle? _____
Are you experiencing any female related complaints at this time? ☐ Yes ☐ No Explain _____
_____
Have you experienced any problems in the past? ☐ Yes ☐ No
How many pregnancies?_____ How many births?_____ Did you have difficulties or complications during pregnancy(s) or delivery(s)?_____

Referred by: _____

THANK YOU FOR YOUR COOPERATION