Confidential Health History

Today's Date: ____________________

Name: ________________________________ Birthdate: ____ /____ /____
Please Print Clearly — Month Day Year

Home Phone: ____________________
Cell Phone: ____________________
Work Phone: ____________________

Address: ____
Street City State Zip

Status: S M W D
(Circle One)

Responsible Party: ____ Social Security #: ______________________

Occupation: ____ Employer: ________________________________

Primary Insurance Company: ______________________________________ ID #____________________________

Name of Insured: ____ Date of Birth: ______________________

In case of 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? Be as specific as possible:

____

____

____

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

____

____

____

Medications including vitamins currently taken:

____

____

Allergies (drugs, foods, airborne pollens, etc.):

____

____

Dietary preferences/restrictions:

____

____

Routine physical exercise: Type ____________________ Times per week __________

Tobacco	**Amount**	**Caffeine**	**Amount**	**Alcohol**	**Amount**
☐ Current packs/day	________	☐ Coffee	________	☐ Wine	________
☐ Previous packs/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 needs.

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
Have you experienced any problems in the past? ☐ Yes ☐ No
How many pregnancies? ____________ How many births? ____________
Did you have difficulties or complications during any pregnancies or deliveries? ☐ Yes ☐ No
If yes, describe: ____

Referred by: ____

Thank you!