DR. TODD FRISCH

Confidential Health History

Today's Date: _____

Name: _____ Birthdate: ____ /____ /____ Home Phone: _____
Please Print Clearly Month Day Year Cell Phone: _____
Email: _____ Work Phone: _____

Address: _____ Status: S M W D
Street City State Zip (Circle One)

Responsible Party: _____ Social Security #: _____

Occupation: _____ Employer: _____

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!