full moon
healing center

PERSONAL INFORMATION **TODAY'S DATE:**

NAME:
ADDRESS City State: Zip Code
HEIGHT**:** WEIGHT: DATE OF BIRTH**:** AGE: GENDER**:**
PHONE: HOME MOBILE WORK
EMAIL ADDRESS:
EMERGENCY CONTACT:
STATUS: ☐SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER:
NUMBER OF CHILDREN & AGES:
REFERRED BY:
HAVE YOU RECEIVED NET BEFORE? ☐ YES ☐ NO IF YES, WHEN AND FOR WHAT PURPOSE?

OCCUPATIONAL INFORMATION

STATUS:☐***FULL TIME*** ☐***PART TIME*** ☐***SELF EMPLOYED*** ☐***RETIRED*** ☐***UNEMPLOYED*** ☐ ***STUDENT*** ☐***OTHER:***
EMPLOYER NAME:
EMPLOYER ADDRESS:
EMPLOYER PHONE:
OCCUPATIONAL STRESS (PHYSICAL/CHEMICAL/PSYCHOLOGICAL)
AVERAGE HOURS OF WORK/STUDY PER WEEK:

PHYSCIAN INFORMATION

PRIMARY DOCTOR**:** PHONE:
ADDRESS:
DATE OF LAST VISIT:

MISSED APPOINTMENT POLICY

If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged full price for missed appointment.

☐ I understand cancellation policy.

full moon
healing center

GENERAL HEALTH INFORMATION

WHAT IS YOUR INTENTION FOR THIS TREATMENT?
WHAT ARE YOUR GOALS FOR YOUR HEALTH IN GENERAL?
ARE YOU CURRENTLY BEING TREATED FOR A MEDICAL CONDITION? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:
ARE YOU CURRENTLY EXPERIENCING ANY ACUTE OR CHRONIC PAIN? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE THE LOCATION, QUALITY AND DURATION OF THE PAIN (S)
PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS (INCLUDE DATES):
ARE YOU CURRENTLY IN THERAPY? IF SO, WHO IS YOUR THERAPIST?
PLEASE DESCRIBE ANY SIGNIFICANT TRAUMAS OR ACCIDENTS (PHYSICAL OR EMOTIONAL):
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (PLEASE MARK BOTH PAST & PRESENT ONGOING USE) ☐ ANTACIDS ☐ ASPIRIN ☐ SEDATIVES ☐ ALLERGY ☐ LAXATIVES ☐ PAIN KILLERS ☐ INSULIN ☐ ANTIHISTAMINES ☐ APPETITE REDUCERS ☐ TYLENOL ☐ GLUCAGON ☐ ASTHMA MEDICATION ☐ FIBER SUPPLEMENTS ☐ ANTIDEPRESSANTS ☐ DIURETICS ☐ ANTIBIOTICS ☐ IBUPROFEN ☐ SLEEP AIDS ☐ THYROID REPLACEMENT ☐ BLOOD PRESSURE PILLS PLEASE LIST ANY OTHERS MEDICATIONS:
DO YOU HAVE ANY DRUG OR FOOD ALLERGIES? ☐ YES ☐ NO IF YES, PLEASE LIST
PLEASE LIST ANY HERBS OR SUPPLEMENTS YOU ARE CURRENTLY TAKING (not already listed above):
PLEASE DESCRIBE YOUR TYPICAL DAILY FOOD & DRINK INTAKE BELOW:

BREAKFAST	
LUNCH	
DINNER	
SNACKS	

ONLY FOR PREGNANT OR POSTPARTUM PATIENTS

HOW MANY WEEKS PREGNANT:
GENDER OF BABY:
DUE DATE:
BIRTH DATE OF BABY:
HOW ARE YOU FEELING ABOUT YOUR BIRTH (EITHER PAST OR UPCOMING):
DESCRIBE YOUR IDEAL BIRTH:
HAVE YOU EXPERIENCED ANY COMPLICATIONS WITH YOUR PREGNANCY? IF SO, PLEASE DESCRIBE:

full moon
healing center

HOW MANY WEEKS PREGNANT:
GENDER OF BABY:
DUE DATE:

ANY OTHER COMMENTS: