Beth Quintana, ND
9728 Greenwood Av N
Seattle, WA 98103
206.602.7140

HEALTH HISTORY INFORMATION

Date: _____

Last Name: _____ First Name: _____ Preferred Name: _____

Birthdate: _____ Gender Identity: _____ Preferred Pronouns: _____

Note: *This is a confidential record and will not be released, except when you provide written authorization to do so.*

PRESENT HEALTH CONCERNS/REASON FOR VISIT

List your most important health concerns in order of significance.	Prior diagnosis of this problem? What was diagnosis?
1.	
2.	
3.	

Who is your Primary Care Provider (PCP)? _____

Please list any manual therapies you have received (craniosacral therapy, massage, chiropractic, etc.): _____

_____

Do you have any questions about treatment methods or provider? _____

_____

Please list prescription medications that you are currently taking with dosages: _____

_____

Please list over-the-counter medications that you are currently taking with dosages: _____

_____

Please list supplements (vitamins, minerals, herbs, homeopathic remedies) that you are currently taking with dosages: _____

_____

_____

Please list any drug allergies, and severe or life-threatening allergies: _____

_____

PERSONAL HABITS:

Please check any of the following substances that you use regularly:

☐ Tobacco (___# daily) ☐ Alcohol (____# weekly) ☐ Coffee/black tea/cola (____#daily) ☐ Recreational Drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

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Do you move/exercise regularly? □ Yes □ No What kind? _____

How long? _____ How often? _____

Do you have a spiritual practice? □ Yes □ No What kind? _____

Do you spend time outside? □ Yes □ No How often? _____ Do you spend time in nature? □ Yes □ No How often? _____

What are the top stressors in your life currently? _____

_____

How do you manage stress in your life? _____

_____

PAST HISTORY:

Hospitalizations and Major Surgeries: _____

Serious Illnesses and Injuries: _____

Date of last physical/annual exam: _____Date of last blood tests: _____

PERSONAL AND FAMILY HISTORY:

Please check the 'yes' box next to each condition that applies to you or one of your family members. Please note whether the condition is in the past or currently by denoting a 'P' for past, or 'C" for current. Indicate who had the condition under'Relation'.

	YES	RELATION	DATE RESOLVED Past (P)/Current(C)		YES	RELATION	DATE RESOLVED Past (P)/Current(C)
Addiction				Eczema			
Allergies				Epilepsy			
Anemia				Headaches and/or Migraines			
Aneurysm				Heart Disease			
Arthritis				Hepatitis			
Asthma				Hypertension			
Cancer				Kidney Disease			
Cerebral Hemorrhage				Mental Illness			
Depression				Skull Fracture			
Diabetes				Stroke			

SOCIAL HISTORY:

Please check those that apply: □ Single □ Married □ Significant other(s)

Do you have any children? □ Yes □ No If yes, please list their age(s): _____

CLIENT NAME (*please print*)**:** _____ **DATE:**_____