www.angelamielehealing.com
info@angelamielehealing.com

Health History

Personal Information

Name: _____

Address: _____

_____

Email: _____

Phone: _____ **Type (*circle one*): home work cell**

DOB: _____
(mm/dd/yy)

Current occupation: _____

Relationship status: _____

Emergency Contact

Name of Emergency Contact: _____

Relationship: _____

Contact Information: _____

_____

Health Information

Describe any significant past or present history concerning your physical health in the following areas:

- **Chronic pain or disability**
- **Accidents or injuries**
- **Cardiovascular events, ie. heart attack, stroke**
- **Head/spine issues ie. concussion, spine injury**
- **Any thing requiring medical intervention or surgery**

_____

_____

_____

_____

Describe any significant past or present history concerning your mental and emotional life (include major life stressors, events, traumas, or medical diagnosis):

_____

_____

_____

_____

_____

Do you have trouble sleeping? _____

Please list medications and any pertinent supplements:

_____

_____

_____

_____

_____

Do you use recreational drugs? _____

Who do you have on your health team currently? _____

_____

_____

Clarifying Questions

Is there any other relevant information that has not been covered here? _____

_____

_____

_____

_____

What are your main concerns and why did you choose this modality? _____

_____

_____

_____

_____

What are your goals regarding your physical, emotional, mental health presently and in the future? _____

_____

_____

_____

_____

_____

_____ _____ _____

(printed name) *(signature)* *(date)*