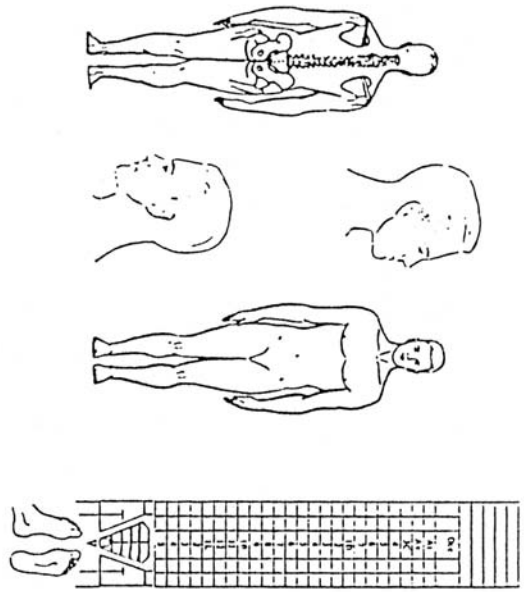


PERSONAL HEALTH HISTORY

Name _____
 Address _____

 Birthdate _____

Phone (home) _____
 Phone (business) _____
 Occupation _____
 Referred by _____

| 0 -Good, No Problem 1 -Very Mild or Occasional 2 -Mild 3 -Moderate 4 -Severe 5 -Very Severe | | | | | | | | | | | | LEAVE THIS AREA BELOW FOR DOCTOR'S NOTES | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | | SYMPTOMS | | | | | | | | | | | | |
| | | | | | | | | | | | | 1 | | | | | | | | | | | | |
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| | | | | | | | | | | | | 11 | | | | | | | | | | | | |
| | | | | | | | | | | | | 12 | | | | | | | | | | | | |
| | | | | | | | | | | | | DATE |  | | | | | | | | | | | |
| | | | | | | | | | | | | NOTES | Referrals _____ X-Ray _____ Insurance _____ | | | | | | | | | | | |
| | | | | | | | | | | | | SUPPLEMENTS | SUMMARY | | | | | | | | | | | |
| | | | | | | | | | | | | VISITS/ TESTS/RS | SUMMARY | | | | | | | | | | | |

