



**Dr. Nate Greenstein**  
**Patient Health History (1 of 2)**

Please complete all pages of the health history form. Be as complete and accurate as possible. If something does not apply, put N/A for not applicable. **Please print or type.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

List the major health concerns in your order of importance. Describe each one in detail, as to its location, nature and occurrence. \_\_\_\_\_

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Describe the most significant measures taken-to-date to improve your health concerns including physician(s) seen, diagnostic tests performed, recommendations made and treatments rendered. \_\_\_\_\_

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Concerning your past history, list, briefly describe, and give the dates of **any** past illness, sickness, accident, injury, surgery and dental work. \_\_\_\_\_

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List and give the dosage of all prescription and non-prescription medications you are **currently taking**, when you started them, the reason for them and the results. \_\_\_\_\_

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List and give the dosage of all prescription and non-prescription medications you **have taken in the past**, when you started and stopped taking them, the reason for them and the results. \_\_\_\_\_

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List the nutritional supplements you are currently taking, including the brand name, content and potency. Indicate the frequency which they are taken. \_\_\_\_\_

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Dr. Nate Greenstein
Patient Health History (2 of 2)

Rate your current stress level on a scale of 1 to 10. (circle one number)

1 2 3 4 5 6 7 8 9 10
Extremely Mild Mild Moderate High Severe

Rate your stress level for the past year. (circle one number)

1 2 3 4 5 6 7 8 9 10
Extremely Mild Mild Moderate High Severe

Rate your stress level for the past five years. (circle one number)

1 2 3 4 5 6 7 8 9 10
Extremely Mild Mild Moderate High Severe

List the amount and type consumed or used for each of the following:

Water Coffee Tea
Soda Alcohol Tobacco

Are you on a special diet or have specific eating habits? No Yes

If yes, explain:

Indicate your current eating habits:

How many meals per day? How many snacks per day?

What are your snacks?

Describe your average breakfast:

Describe your average lunch:

Describe your average dinner:

List the three healthiest foods you eat during the average week.

List the three worst foods you eat during the average week.

Do you experience any food cravings, sensitivities or allergies? No Yes

If yes, explain:

How many times a week do you eat fish?

How many times a week do you eat raw nuts or seeds?

How many times a week do you eat out?

Are you on an exercise program? No Yes

If yes, explain:

Do you wear: Orthotics No Yes Heel Lift No Yes Special Shoes No Yes

List and explain your family health history for all current and past significant health problems.(ex. heart disease, cancer)

How motivated are you in improving or overcoming your problems? Circle one number

1 2 3 4 5 6 7 8 9 10
Not very motivated Somewhat motivated Fairly motivated Very motivated Extremely motivated

What expectations do you have concerning treatment?

What reservations do you have concerning treatment?

What would you consider a positive outcome from treatment?

Please read, sign and date the following:

I completed this health history to the best of my knowledge. It is considered up-to-date, factual and an accurate representation of my health. I will notify you of any future changes with my health history.

Patient/Legal Guardian: Date: