HEALTHY GUT HEALTHY BRAIN

Health and Demographic Information Form

Note: This form collects sensitive personal information. Please ensure that all data is handled securely, in compliance with privacy laws, and is used solely for medical care, billing, and health management purposes.

First Name: ___________________________________

Last Name: ___________________________________

Date of Birth: ________________(MM/DD/YYYY)

Age: __________

Gender: _____________________________________

Address:

Street:

____

City/State

____

ZIP Code:

____

Phone Number: ______________________________

Email:____

Demographic Information:

Marital Status:________________________________

Primary Language: ___________________________

Occupation:___________________________________

Health Information:

Primary Care Physician: ______________________

Dentist:______________________________________

Emergency Contact:

Name:______________________________________

Relationship:_________________________________

Contact Number:______________________________

Email:_______________________________________

Medical History:

Do you have any current or past medical conditions? ☐ Yes ☐ No

If yes, please list:

____

____

Allergies: ☐ Yes ☐ No

If yes, please specify (medications, foods, environmental, EMF's):

____

____

____

Medications: ☐ Yes ☐ No

____

____

____

Family Medical History:

Are there any significant family medical conditions? ☐ Yes ☐ No

If yes, please specify:

____

Lifestyle:

Smoking: ☐ Never ☐ Former ☐ Current - How many per day? _____

Alcohol: ☐ Never ☐ Occasionally ☐ Regularly - How many drinks per week? _____

Exercise: ☐ None ☐ 1-2 times/week ☐ 3+ times/week

Insurance Information:

Insurance Provider: __________________________

Policy Number: ________________________________

Group Number:_________________________________

Name of Insured:

____

Relationship to Patient: _______________________

Consent: I certify that the information provided above is accurate to the best of my knowledge.

Signature:

____

Date: _______________________ (MM/DD/YYYY)