

**MoonWater Healing Center**  
6960 North Sheridan Road, Chicago, Illinois 60626

**Medical History Intake Form**

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

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Birth date: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact's phone number: \_\_\_\_\_

Has a doctor or health professional ever told you that you have or had any of the following conditions?

- |                                |                          |
|--------------------------------|--------------------------|
| Back Pain                      | Cancer                   |
| Heart problems/heart disease   | Joint replacement/repair |
| Joint, Tendon or Muscular Pain | Asthma                   |
| Osteoporosis                   | Skin Problems            |
| Pacemaker                      | Stroke                   |
| High or low blood pressure     | High or low blood sugar  |
| Chest pain/angina              | High cholesterol         |
| Blood clots                    | Emphysema                |
| Shortness of breath            | Faintness on exertion    |
| Coughing/Wheezing on Exertion  | Dizziness                |
| Blackouts                      | Severe headaches         |

Do you smoke? Yes No Do you use alcohol? Yes No Are you pregnant? Yes No

Please explain if you checked any of the above boxes: \_\_\_\_\_

How often per week do you exercise? \_\_\_\_\_

What forms of exercise do you practice? \_\_\_\_\_

Are you under a Doctor's care? Yes No If yes, please explain \_\_\_\_\_

Please list any other medical conditions you have: \_\_\_\_\_

Accidents including motor vehicle (Include Date): \_\_\_\_\_

Surgeries (Include Date): \_\_\_\_\_

Medications: \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I have disclosed all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that these services are a health aid and not a substitute for a doctor's care Cancellations and changes within 24 hours of my appointment are subject to the full session fee.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_