AURA
HEALTH & SPA

Name_____ Date_____
Address _____ Apt.# _____
City _____ State _____ ZIP _____
Shipping Address _____

_____

Home Phone (____) ____-_____ Work Phone (____) ____-_____
e-mail address: _____

REFERRED BY: _____
Occupation _____ Employer _____
Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____
Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here):

_____
_____
_____

Previous treatments for this complaint _____

_____
_____
_____

Other complaints or problems: _____

_____
_____
_____

Current medications/drugs being taken: _____

_____
_____
_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____
_____
_____

Nutritional supplements you are taking:_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

HISTORY:

List any major illnesses (with approx. dates):

_____

_____

_____

List any surgery or operations with approx. date: _____

_____

_____

_____

Past Accidents or injuries: _____

_____

_____

_____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ___

Name of Child (optional)	Age	Sex	Any physical conditions or concerns?
_____	___	M/F	_____
_____	___	M/F	_____
_____	___	M/F	_____

Any family history of serious illnesses (circle those which apply):

Cancer / Diabetes / Heart / Other

_____

_____

_____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier?_____

_____

SIGNED: _____ DATE _____