Welcome to O'Hana Natural Health

O'Hana Natural Health | 1641 W. Main St, Suite 314, Alhambra, CA 91801 | (626) 425-8548 | www.drpei.com

NEW PATIENT FORM

(Please print clearly)

Date: _____

Last Name: _____

First Name: _____Middle Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ZIP: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

E-mail address: _____

Date of Birth (mm/dd/yr): _____ Age: _____

Driver License #: _____Marital Status: _____

Gender: M / F Ht: _____ Wt: _____

Occupation: _____ Employer/Phone#: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

How did you hear about us? Whom may we thank for your referral? (Please specify)

I certify that the above information is correct to the best of my knowledge. I will not hold O'Hana Natural Health (Dr Pei Vuong D.C.), or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I permit a copy of this authorization to be used in place of the original as permanent record. I understand that I am financially responsible for any balance.

X_____ _____

Patient/Guardian Signature Date

Please see reverse side

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HEALTH HISTORY QUESTIONAIRE

(Please print clearly)

NAME: _____ **DATE:** _____

** Chief complaint (reason you are here): (use separate sheet if more room needed)*

_____

** Previous treatments for this complaint*_____

_____

** Other complaints or problems: (use separate sheet if needed)*_____

_____

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

_____

** Current medications/drugs, supplements, herbs being taken currently: (use separate sheet if needed)*

** List any major illnesses (with approx. dates):*_____

_____

** List any surgery or operations with approx. date:* _____

_____

** Past Accidents or injuries:*_____

** Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other*

_____

** Are you pregnant or potentially pregnant? ____Yes ____No ____ Not sure*

Daily Stress

** Stress Level : Low / Med / Severe /* _____

** Work Activities: Heavy / Light Labor / Mostly sitting / standing / walking* _____

** Meal Per Day: 1 2 3 4 5 6+ : Any special Diet:* _____

**Water Intake per day: <8oz 16-32oz 32-64oz 64+oz*

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

Cigarettes _____ *Coffee*_____ *Alcohol* _____ *Soda* _____

**Sleep per day: <5hrs 5-6hrs 6-7hrs 7-8hrs 8+hrs*

** Do you use a microwave? ___Yes___No, *How close is the home smart meter to your bedroom?*_____

I hereby authorize the doctor and practitioners who are in O'Hana Natural Health to support my conditions he/she deems appropriate within medical scope of practice. All questions contained in the questionnaire including system surveys are strictly confidential and will become part of your medical record.

*X*_____ _____

Patient/Guardian Signature *Date*