Minnesota Clinic for Health and Wellness

Medical / Health History

Client Name: _____

Date of Birth: _____

Date: _____

Recent Medical Care:

Clinic or Doctor's Name_____ Phone_____

Address_____

_____

Psychiatrist: _____Phone_____

Address_____

_____

Medications and name of prescribing physician_____

_____

_____

_____

Significant health issues _____

_____

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