

GRASS ROOTS MEDICAL CLINIC
PATIENT HISTORY FORM
5330 MANHATTAN CIRCLE SUITE C
BOULDER, CO 80303
303-499-9399

Please print
Provide as much detail as possible

PATIENT NAME:

ADDRESS:

HOME PHONE: _____

WORK PHONE: _____

CELL: _____

DOB: _____

AGE: _____

SSN: _____

GENDER: MALE _____ FEMALE _____

HEIGHT: _____ WEIGHT: _____

EMAIL ADDRESS:

OCCUPATION:

MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____

NAME OF SPOUSE:

HOW DID YOU HEAR ABOUT US?

PATIENT NAME: _____

MAJOR COMPLAINTS AND SYMPTOMS:

WHEN DID YOUR CONDITION BEGIN?

IN WHAT WAYS DOES THE CONDITION LIMIT YOU?

WHAT MEDICATIONS OR OTHER TREATMENTS HAVE YOU TRIED:

WERE THOSE TREATMENTS SUCCESSFUL?

I _____ have answered all questions honestly regarding my health status. Any relationship established between GrassRoots Medical Clinic, it's doctors or any related agents and their recommendations, are solely related to my personal health and do not replace the need for a primary care physician in regards to regular preventative health care. Moreover, I in no way represent the interests of federal law enforcement, the DEA, police or any related state or federal agency.

PATIENT SIGNATURE _____

DATE _____