# M.A.C. Alternative Therapies, Inc.

28469 US Highway 19 No. #402, Clearwater, Florida 33761. Phone 727.723.3888 Fax. 727.796.2888

**Name:**_____**Date:**_____

**Address:**_____

**City:**_____ **State:**____ **Zip:**_____ **Occupation:**_____ **Marital Status: S M D W**

**Name of Spouse:**_____ **Describe health of spouse:**_____
**Number of Children:** _____
**Name of Child:**_____ **Age:**_____ **M__F__ Any physical conditions or concerns?**_____
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**Home Phone:** _____**Cell Phone:** _____ **Work:** _____

**Email Address:** _____ **Referred by:** _____

**Date of Birth:** _____**Age:** _____**M__F__ Height:** _____ **Weight:** _____

**Overall health: (circle one) Excellent / Good / Fair / Poor / Other:** _____

**Chief complaint or 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? Please list name & give approximate 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 approximate dates):**_____
_____

**List any surgeries or operations with approximate date:**_____
_____

**Past accidents or injuries:** _____
_____

**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?** _____

**Print Name:** _____**Signed:** _____