Dr. Aihan Kuhn Patient Information

Name ________________________________Sex ________Date of birth _____________Age_______

Address _______________________________Town ________________State ________Zip________

Cell Phone ________________________ EMAIL ____

Occupation ___________________________ Employer ______________________________________

Address ____

Your weight ______Your height ______Do you smoke? ______Do you drink? _____Using Drug?_____

Reason for Coming to the Healing Retreat:

____

Are you currently taking medication: No Yes Please list:

____

Have you had or currently have any of the following: (please circle)

Hypertension	Heart Disease	High Cholesterol	Stroke	Abnormal Bleeding
Seizures	Diabetes	Thyroid Problem	Cancer	Migraine Headaches
Anemia	Peptic Ulcer	Cirrhosis	Hepatitis	Tuberculosis
Head injury	HIV Positive	Schizophrenia	Depression	Other ____________

History of Surgeries: ____

Do your relatives have any of the above?

____

Have you ever had a blood transfusion? _______When __________Why________________________

Activities: **Please circle**

Reading	Writing	Art	Music	Computer	Sewing	Hunting	Flying	Golfing
Tennis	TV	Swimming	Jogging	Walking	Cards	Dancing	Tai Chi	Aerobics
Biking	Other							

Have you seen other Alternative Therapists? ______Type of Therapy_____________________________

When ___________________ Result____

Do you have food allergy? No Yes If yes, please list the foods you are allergic to:

Are you vegetarian: No Yes

Please sign here _____________________________ Date:__________________________