sacredbee

Patient In-Take Health Summary

Name: _____Date:_____
Address:_____
Date of Birth:_____ Email:_____
Gender:_____Phone/s_____
Physician's Name:_____Phone:_____
In Case of an Emergency Contact:_____Phone:_____
Relationship:_____
Referred by:_____

Current symptoms:_____
_____

Have you been given a diagnosis for this/these problems? If so, when/what?
_____
_____
_____

Please indicate primary treatments you have tried and whether they have helped:
_____
_____
_____

What current medications are you taking:_____
_____
_____

Health History (surgeries, traumas, infections, illness, etc):
_____
_____
_____
_____
_____
_____

Supplements:_____
_____
_____
_____
_____

Allergies (airborne, food, contact):_____
_____
_____

Sexually transmitted diseases (including HIV, Herpes):_____
_____
_____
_

Describe your specific symptoms:_____
_____
_____
_____
_____
_____
_

Diet: Vegetarian Y/N meals per day_____ Caffeinated Drinks/day_____
Alcoholic drinks per day_____Exercise per week_____

Signature:_____**Date**_____

RESULTS OF TEST STING:

HIVE PRODUCTS: (honey, pollen, propolis, royal jelly, bee venom, bees wax)