New Patient Information Form

Please Print Clearly:

Name: _____ Date: _____

Address: _____ Soc. Sec. # _____

City: _____ State: _____ Zip: _____

E-mail Address: _____ Referred By: _____

Home phone: _____ Work Phone: _____

Occupation: _____Employer: _____

Date of Birth: _____ Age: _____ Sex: M/F

Height: _____ Weight: _____

Overall Health (circle one): Excellent Good Fair Poor

Chief Complaint (reason you are here): _____
_____

Previous Treatments for This Complaint: _____
_____

Other Complaints: _____
_____
Current Medications / Drugs: _____
_____

Are You Currently Under the Care of a Physician or Other Health Professional? (If yes, please give name and date of last visit)_____

Nutritional Supplements You Are Taking: _____
_____

Do You Smoke or Drink Coffee or Alcohol? (If yes, indicate how much)
Cigarettes_____ Coffee_____ Alcohol_____

List Any Major Illnesses (with approximate dates):
_____
_____

List Any Surgery/Operations (with approx. dates): _____
_____

Past Accidents or Injuries: _____

Marital Status: S M D W Name of Spouse: _____

Describe Health of Spouse: _____ # of Children_____

List Any Physical Conditions or Concerns of Your Children:
_____

Any Family History of Serious Illness (please circle): Cancer Diabetes / Heart / Other:
_____

What Can We Do to Make You Happier? _____
_____