NEW PATIENT INFORMATION FORM

Please print clearly:

Name____ Date_________

Address____ Apt.#________

City______________________________ State____________ Zip__________

Home Phone(____) ____-______ Cell(____) ____-_______ Work (____) ____-_______

E-mail address ____

REFERRED BY:____

Occupation____

Employer____

Date of Birth____________________Age ____ Sex: M/F Height _____ Weight _____

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

Chief complaint (reason you are here): ______________________________________

How often?____

How severe?____

First began? ____

How does it interfere with your life?_____________________________________

____

Getting worse? ____

Getting better? ____

What would happen if it were to become worse?______________________________

____

____

Previous treatments for this complaint_______________________________________

____

Other complaints or problems:

Health complaints	How often	How severe?	First began?

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Current medications/drugs being taken: (use separate sheet if needed)________________
____
____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and 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 approx. dates):_______________________________________
____
List any surgery or operations (with approx. date):___________________________________
Past accidents or injuries:____
____
____

Marital Status: S M D W Name of Spouse ______________________________
Describe health of spouse:_____________ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
____________________________	_____	M/F	______________________________
____________________________	_____	M/F	______________________________
____________________________	_____	M/F	______________________________

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?____

SIGNED____ DATE_____________