NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____
Address _____ Apt.# _____
City _____ State_____ Zip _____
Shipping Address _____
_____
Home Phone (____) ____-_____Work Phone (____) ____-_____
Cell Phone (____) ____-_____ 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): (use separate sheet if more room needed)
_____
Previous treatments for this complaint _____
_____
Other complaints or problems: (use separate sheet if needed) _____
_____
_____
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: _____
_____
_____
Check the following items which apply to you and indicate the amount used:

□ Coffee	_____	□ Artificial Sweetener	_____	□ Ice Cream	_____
□ Tea	_____	□ Antacids	_____	□ Alcohol	_____
□ Soft Drinks	_____	□ Laxatives	_____	□ Cigarettes	_____
□ Diet Soft Drinks	_____	□ Candy	_____	□ Other Tobacco Products	__

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Office Use Only:

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Name: _____ Date_____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date:_____

_____

Past Accidents or injuries: _____

_____

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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 _____

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