NEW PATIENT INFORMATION FORM

Please print clearly:

Name____ Date____________

Phone (____) ____-_______ Email:___________________________________

Referred By: ____

Occupation:_______________________ Employer:__________________________

Date of Birth:____________________ Age:_____ Sex: M/F Height_____ Weight______

Chief Complaint:

____

Previous Treatment for this complaint:

____

Other Complaints or problems:

____

Current Medications/ Drugs being taken: _____________________________________

____

Are you currently under the care of a physician or 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: ____

____

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?

____

SIGNATURE: _______________________________________ DATE:____________