

**NEW PATIENT INFORMATION FORM**

***Please print clearly:***

**Name Date**

**Address Apt. #**

**City State ZIP**

Shipping Address

**Cell Phone (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Home/Work 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:

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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

 M/F

Are you pregnant? NO YES

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