New Patient Form

Name:____

Address:____

Phone Number:___________________DOB:__________________

Email:___________________________Sex:_________________

Please list your 4 major health concerns in order of importance:

1. _______________________2. ______________________

3. _______________________4. ______________________

How many alcoholic beverages do you consume per week?

How many caffeinated beverages do you consume per day?

How many times do you eat out per week?

List the three worst foods you eat during the average week:

1.

2.

3.

List the three healthiest foods you eat during the average week:

1.

2.

3.

How many times do you work out per week & for how long?

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Rate your stress level on a scale of 1-10 during the average week: