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THE BODY HAS THE INNATE ABILITY TO HEAL GIVEN THE PROPER TOOLS

NEW PATIENT INTAKE FORM

Name_____ Date_____

Address_____ Apt.#_____

City_____ State_____ ZIP_____

Shipping Address_____

_____

Cell Phone (____) _____-_____ Home 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)

_____

_____

_____

How long have you been suffering with this complaint? _____

Previous treatment for this complaint: _____

_____

Other complaints or problems: (use separate sheet if needed)_____

_____

_____

How long have you been suffering with this complaint? _____

Previous treatment for this complaint: _____

_____

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):_____

_____

ALLERGIES : List all drug, food and environmental allergies:_____

_____

Nutritional supplements you are taking:_____

_____

_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee_____ Alcohol_____

Recreational drug usage: _____

Exercise: _____

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 _____

Covid Vaccine and/or booster? Y/N_____ How many? _____

Recent Vaccines (flu, pneumonia, tetanus, shingles, other) Y/N _____
Please list _____

Recent Contact with newly Vaccinated Person? Y/N_____

Any household pets or other animals you or family members are in close contact with: _____

FAMILY HISTORY: Please list any medical conditions that run in your family (parents, siblings, grandparents, aunts and uncles): _____

_____

_____

HISTORY OF EATING DISORDER? (circle one): Yes / No

Please detail dietary intake for the 2 days prior to this appointment:

Breakfast:

Lunch

Dinner:

Snacks/Desserts:

Water in glasses or ounces:

Other drinks:

Breakfast:

Lunch

Dinner:

Snacks/Desserts:

What can I do to make you happier?_____

_____

_____

SIGNED:_____ DATE_____