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NEW PATIENT INFORMATION

Patient Information

Date_____ Home Phone (_____)_____ Cell Phone (_____)_____

Name_____ Work Phone (_____)_____

Address _____ E-mail _____

City _____ State _____ Zip_____

Sex_____M _____F Age_____ Birthdate _____ Marital Status/minor _____

Patient Employer/School_____ Occupation _____

REFERRED BY:_____

In case of emergency who should be notified?_____ Phone (_____)_____

Health Information

Overall health (circle one): Excellent / Good / Fair / Poor / Other:_____

Chief Complaint (reason you are here):_____

_____

Previous treatments for this complaint:_____

Other complaints or problems:_____

Current medications/drugs being taken:_____

_____

Nutritional Supplements you are taking:_____

Are you currently under the care of a physician or other health care professionals? (If yes, please give name and date of last visit):_____

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

Cigarettes_____ Coffee _____ Alcohol_____

What can we do to make you happier?_____

SIGNED:_____ **DATE:** _____