Health Matters

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____
Address _____ Apt.# _____
City _____ State_____ ZIP_____
Shipping Address _____
_____
Home Phone (____) ____-_____ Alternate 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
What would you like your overall health to be? Excellent Good Fair Poor

What is your level of commitment to achieving this goal? 1 2 3 4 5 6 7 8 9 10

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) _____
_____

Are you currently under the care of a physician or other health care professional(s)?
(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_____
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Office Use Only:

Health Matters

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Name: _____ Date_____

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: Excellent Good Fair Poor Number of children _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Auto Immune Illnesses _____

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

_____

What do you hope to achieve if you come under care with our office? _____

_____

What have you, yourself, done to achieve the above goals or results? _____

_____

SIGNED:_____ DATE _____