NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

S.S.# _____

Occupation _____ Employer _____

Home Phone (____) _____-_____ Mobile Phone (____) _____-_____

e-mail address: _____

Preferred Method of Communication: _____

Patient Date of Birth ____/___/____ Age ____ Sex: M/F Height _____ Weight _____

REFERRED BY: _____ _____

INSURANCE INFORMATION

Insurance Company _____

Guarantor _____ Guarantor Date of birth _____

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	_____

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

_____

Chief complaint (What can we do to make you happier?): _____

_____

_____

Previous treatments for this complaint _____

_____

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

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Medication Allergies: (use separate sheet if needed) _____

_____

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Office Use Only:

Therapy_____ **Xrays**_____

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: _____

_____

HISTORY:

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

Cigarettes _____ Coffee _____ Alcohol_____

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date:_____

_____

Past Accidents or injuries: _____

_____

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:

_____

SIGNED:_____ DATE _____

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Office Use Only: