

Health Matters

NEW PATIENT INFORMATION FORM

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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:

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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?
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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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 _____