Picture of Health Family Chiropractic and Nutrition

NEW PATIENT INFORMATION FORM

Please print clearly:

Name_____ Date_____

Address_____ Apt. #_____

City_____ State_____ ZIP_____

Shipping Address_____

Home Phone ( ) _____-_____ Work 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 is needed) _____

_____

Previous treatments for this complaint: _____

_____

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

_____

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):_____

Nutritional supplements you are taking: _____

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

Cigarettes_____ Coffee_____ Alcohol_____

Office use only:

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NEW PATIENT INFORMATION FORM

Name: _____ Date: _____

HISTORY:

List any major illnesses (with approximate dates): _____

_____

List any surgery or operations (with approximate dates): _____

_____

Past accidents or injuries: _____

_____

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	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other (if other, please explain) _____

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

_____

What can we do to make you happier? _____

_____

SIGNED: _____ DATE: _____