

# Patient Information Form

PLEASE PRINT CLEARLY

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Which number do you prefer to be reached at? (Circle) Home / Work / Cell

Email address \_\_\_\_\_

Who/what referred you to our office? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M / F Height \_\_\_\_\_ Weight \_\_\_\_\_

Overall Health (Circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Chief concern (reason you are here): \_\_\_\_\_

\_\_\_\_\_

Previous treatments for this complaint: \_\_\_\_\_

\_\_\_\_\_

Other complaints or problems: \_\_\_\_\_

\_\_\_\_\_

Current medications/drugs being taken: \_\_\_\_\_

\_\_\_\_\_

Nutritional supplements you are taking: \_\_\_\_\_

\_\_\_\_\_

Women only: Are you pregnant? Yes / No / Uncertain

Do you use birth control? Yes / No

Check the following items which apply to you and *indicate the amount used*:

<input type="checkbox"/> Coffee	<input type="checkbox"/> Artificial Sweetener	<input type="checkbox"/> Ice cream
<input type="checkbox"/> Tea	<input type="checkbox"/> Antacids	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Soft Drinks	<input type="checkbox"/> Laxatives	<input type="checkbox"/> Cigarettes
<input type="checkbox"/> Diet Soft Drinks	<input type="checkbox"/> Candy	<input type="checkbox"/> Other Tobacco Products

**Please complete other side →**

List any major illness with approx. dates: \_\_\_\_\_  
\_\_\_\_\_

List any surgery or operations with approx. dates: \_\_\_\_\_  
\_\_\_\_\_

Past accidents or injuries: \_\_\_\_\_  
\_\_\_\_\_

Marital Status: S M D W Name of spouse: \_\_\_\_\_

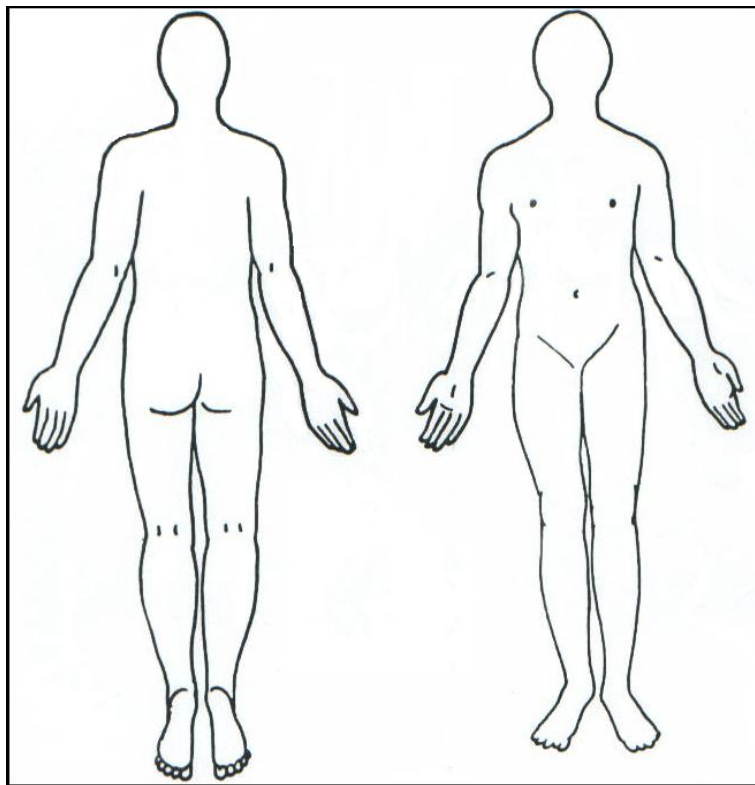
Describe health of spouse: \_\_\_\_\_ Number of children, if any: \_\_\_\_\_

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other \_\_\_\_\_  
\_\_\_\_\_

What is your level of commitment to improve your health? \_\_\_\_\_ %

What can we do to make you happier? \_\_\_\_\_  
\_\_\_\_\_

**Important!** Please mark any locations where you have scars including episiotomy, piercings, tattoos, etc.



Signed: \_\_\_\_\_

Date: \_\_\_\_\_