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 back of sheet if more room needed)

____

Other complaints or problems: (use back of sheet if needed)_______________________

____

Previous treatments for this complaint: ______________________________________

____

Current medications/drugs being taken: (use back of 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? Y / N (if yes indicate how much)

Cigarettes ______________ Coffee _________________ Alcohol________________

Do you have a spiritual/religious preference?___________________________________

Would you be open to receiving prayer today? Y / N

Do you have any dietary restrictions or preferences? _____________________________

Do you have any allergies/sensitivities? Gluten__________

Drugs______________ Foods_______________ Environmental____________ Seasonal____________

What kind of exercise do you do?____

How often_____________________ Duration__________________________

Do you have trouble falling asleep? Y / N Can't stay asleep Y / N Bad dreams Y / N

Any other sleep problems?____

Do you have any silver amalgam fillings?___________ Root Canals?___________

NATURAL HEALTH CENTER OF THE ROCKIES

NEW PATIENT INFORMATION FORM

Name: ______________________________________ Date ____________

HISTORY:

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

____

List any surgery or operations with approx. date: ___________________________

____

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	___________________________

WOMEN ONLY:

Are you pregnant Y / N Are you nursing Y / N Date of last menstrual period__________

Do you have regular monthly periods? Y / N

Circle any of the following symptoms you experience associated with your period:

Cramping Bloating Moody Cravings Heavy Bleeding

Back Pain Headaches Clots

Circle any menopausal symptoms you are experiencing:

Hot Flashes Bloating Weight Gain Mood Swings Depression

==

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:

____

What can we do to make you happier? _________________________________

____

SIGNED: ____________________________________ DATE ____________