



**NEW PATIENT INFORMATION FORM**

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*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? \_\_\_\_\_



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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: \_\_\_\_\_

\_\_\_\_\_  
=====

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

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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 \_\_\_\_\_