NEW PATIENT INFORMATION FORM

NATURAL HEALTH CENTER OF THE ROCKIES

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: _____

Vaccination History: _____

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 Canôt 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: _____

_____

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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 _____