NEW CLIENT INFORMATION FORM

Name_____ Date_____
Address _____ Apt.# _____
City _____ State_____ ZIP_____
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 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_____

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 ____
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 I do to make you happier? _____

_____

SIGNED:_____ DATE _____