

## NEW PATIENT INFORMATION FORM

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**Please print clearly**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Apt.# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Shipping Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

YES, I would like to receive the FREE monthly e-mail Newsletter

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: \_\_\_\_\_

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

Describe health of spouse: Excellent / Good / Fair / Poor Number of children if any \_\_\_\_

Name of Child \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Any health conditions or concerns? \_\_\_\_\_

\_\_\_\_\_ M/F \_\_\_\_\_

\_\_\_\_\_ M/F \_\_\_\_\_

\_\_\_\_\_ M/F \_\_\_\_\_

\_\_\_\_\_ M/F \_\_\_\_\_

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) \_\_\_\_\_

=====  
Office Use Only:

**NEW PATIENT INFORMATION FORM**

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

**HISTORY:**

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: \_\_\_\_\_

List any major illnesses (with approx. dates): \_\_\_\_\_

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

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

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

Do you use or consume? (if yes indicate how much/often)

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_

Soda/Diet \_\_\_\_\_ Milk \_\_\_\_\_ Microwave \_\_\_\_\_

**Please circle or answer all that apply:**

Age of mattress \_\_\_ years / months

Age of house \_\_\_ years / months

How long have you lived in your house? \_\_\_ yrs / mth

In your house do you have: \_ carpet, \_ wood, \_ tile

Do you think you have mold in your house? Y N

Do you live near power lines? Y N

Can you see a transmission tower from your yard? Y N

Do you drink ( tap / bottled / distilled ) water?

What kind of toothpaste do you use?  
\_\_\_\_\_

What kind of soap do you use? \_\_\_\_\_

Do you have a pool or use a pool? Y N

Daily exposure to chemicals/pesticides/fumes? Y N

Do you have mercury or gold fillings? Y N

Do you use anti-perspirant? Y N

Exercise regularly? Y N

Work stress? Y N

Physical stress? Y N

Emotional stress? Y N

Sleeping position - side / stomach / back

Pets Y N \_\_\_\_\_

Dogs # \_\_\_\_\_, Cats # \_\_\_\_\_, Birds # \_\_\_\_\_

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

**SIGNED:** \_\_\_\_\_ **DATE** \_\_\_\_\_