



**NEW CLIENT INFORMATION**

Please print clearly:

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

Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ e-mail: \_\_\_\_\_

Social Security# \_\_\_\_\_ or Driver's License # \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Contact phone numbers: #1 (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ #2 (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

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): \_\_\_\_\_

\_\_\_\_\_

Previous treatments for this complaint \_\_\_\_\_

\_\_\_\_\_

Other complaints or concerns: \_\_\_\_\_

\_\_\_\_\_

Current medications/drugs being taken: \_\_\_\_\_

\_\_\_\_\_

Are you currently under the care of a physician or health care professionals? Y/N

Name: \_\_\_\_\_ Date of last visit \_\_\_\_\_

Nutritional supplements you are taking: \_\_\_\_\_

\_\_\_\_\_

Do you smoke, drink coffee or alcohol? Y / N (if yes indicate how much)

Cigarettes/day \_\_\_\_\_ Coffee cups/day \_\_\_\_\_ Alcoholic drinks/week \_\_\_\_\_

Exercise: Record type and amount of exercise over a one week period: \_\_\_\_\_

\_\_\_\_\_

Who may we thank for referring you?

Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SEE REVERSE SIDE OF PAGE**

**MEDICAL and PERSONAL HISTORY:**

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

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

Past Accidents or injuries with approx. dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Circle **Y for yes** and **N for no** to the following questions:

- Y / N Do you have any heart conditions?      Y / N Is your blood pressure normal?
- Y / N Do you have any digestive problems?      Y / N Do you have diabetes?
- Y / N Are you being treated for depression?      Y / N Any respiratory conditions?

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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 _____
_____	___ M/F _____

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

What are you goals from attending this practice? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you prepared to become a working partner towards achieving these goals? Y / N

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