WELCOME

1 PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birthdate _____

Occupation _____

Primary physician _____

Physician phone number_____

Whom may I thank for referring you?_____

_____

2 CONTACT INFORMATION

Home phone _____

Work phone _____

Email _____

Best time and place to reach you _____

_____

Another person whom we may contact if needed:

Name _____

Relationship_____

Home phone _____

Work phone_____

3 MEDICATIONS / HISTORY

List medications or food supplements you are taking.

_____

_____

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

_____

_____

_____

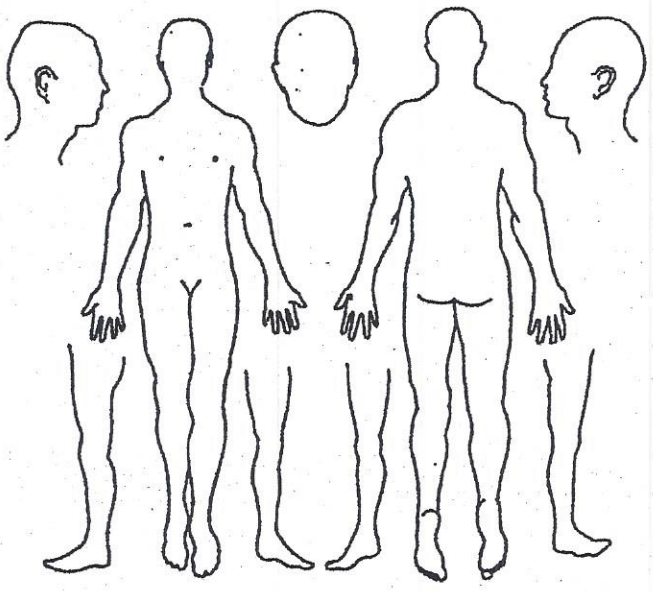
Check illnesses that have occurred in blood relatives.

☐ Diabetes ☐ High blood pressure ☐ Stroke

☐ Cancer ☐ Heart disease ☐ Kidney disease

4

Please indicate painful or distressed areas if any.



Comments: