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PATIENT INFORMATION

Date____________________ (Please Print)

Name________________________________Home Phone #__________________Cell Phone # ___________________

Email____Add email to clinic newsletter list? Yes No

Street Address____City_______________State_____Zip__________

Age_____Birthday_______________________Marital Status: M___S___D___W___SEP___Height:_________Weight:______

Primary Care Physician____

Other Physicians/Therapists seen for current condition(s)____

Occupation____Years doing this work______________________

Is there anything limiting you from care? Yes No ____

How did you hear about our office? ____

In case of emergency who should be notified?_________________________________Phone #______________________

Major complaint(s), in order of importance to you: | **How long ago did this begin?**

1.____ 1. _________________________

2.____ 2. _________________________

3.____ 3. _________________________

4.____ 4. _________________________

How do these conditions impair your daily activities? ____

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For additional concerns, please list on the back of this page.

Medications you are currently taking:

	Drug Name:	For the treatment of:	Taking since:	Prescribed by:
1.	________________	________________	________	________________
2.	________________	________________	________	________________
3.	________________	________________	________	________________
4.	________________	________________	________	________________

For additional medications, please list on the back of this page.

Supplements, taken daily (vitamins, herbs, minerals, etc.): ____

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