Natural Healing Center
NEW PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY:

Name _____ Date_____

Address _____ Apt.# _____

City_____ State _____ ZIP _____

***Cell Phone** (_____) _____-_____ Home Phone (_____) _____-_____

***USED FOR TEXT REMINDERS**

***e-mail address:** _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Emergency Contact _____

Emergency Phone (____) _____-_____ Contact Relation _____

REFERRED BY: _____

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 _____

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Office Use Only:

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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 ___

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

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:

_____

Any other information regarding your health? _____

_____

SIGNED: _____ DATE _____

Guardian's Signature_____ DATE_____