New Life Holistic Center

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Shipping Address _____

Home Phone (_____) _____ - _____ Alternate Phone (_____) _____ - _____

Email address _____

REFERRED BY _____

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), use separate sheet if needed: _____

_____

_____

Other complaints or problems, use separate sheet if needed: _____

_____

_____

Current medications/drugs you are taking: _____

_____

_____

Are you currently under the care of a physician or other health care professional? _____
If yes, please give name and date of last visit.

_____

Nutritional supplements you are taking _____

_____

Are you? (circle one) Vegetarian / Vegan / Neither / _____

Do you smoke, drink coffee or alcohol? If yes, indicate how much per day or week

Cigarettes _____ Coffee _____ Alcohol _____

Office use only:

New Life Holistic Center

NEW PATIENT INFORMATION FORM

Name _____

HISTORY

List any major illnesses, with approximate dates: _____

_____

List surgeries or operations, with approximate dates: _____

_____

Past accidents or injuries with approximate dates: _____

_____

Marital Status (circle one) S M D W If married, 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	_____
_____	_____	M/F	_____

Any family history of serious illness? _____

Circle those which apply: Cancer / Diabetes /Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

SIGNED _____ **DATE** _____