## PATIENT INFORMATION

Last Name ____________________ First Name ______________ Date ____________________

Address __________________________________________________ Zip Code ________

Telephone Home _______________ Work _________________ Cellular ____________________

Email Address: ____________________________________________________________

Age ____________ DOB _______ Occupation ____________________________________

Who to reach in case of an emergency ______________________________________

How did you hear about our clinic? _________________________________________

Are you currently receiving health care? Please circle: Y N

If yes, name of physician: ___________________________________________________

Condition being treated: ____________________________________________________

What are your most important health concerns?

1 ________________________________________________________________________

2 ________________________________________________________________________

3 ________________________________________________________________________

Please list tested or suspected allergies and related symptoms:

Foods ____________________________________________________________________

Seasonal _________________________________________________________________

Drug / other ______________________________________________________________

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

__________________________________________________________________________

Daily Dosage _____________________________________________________________

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)? __________________

Do you smoke? Please circle: Y N

Please read the New Patient Information form. Sign below when you have finished.

*Yes, I have read and understand the items listed on the New Patient Information form.*

**Signature** ________________________________________ **Date** ____________

(If under the age of 16, must be signed by Parent or Legal Guardian.)