Confidential Patient Information Form

Full Name:______________________________ Date:_____/_____/_____

Date of Birth: _____/_____/_____ Sex: Male / Female Age: _____ Height:_____ Weight: _____

Home Address:______________________ City: __________ State: _____ Zip: _______

Phone # : ______________________ Email: ______________________

Preferred communication: Email / Phone Call / Text / Mail

Employer Name: ______________________ Occupation/Work Duties: ______________________

How or from Who did you hear about our office? ______________________

FAMILY: Married : Single : Divorced : Widowed

Spouse Name: ______________________ Spousal Occupation: ______________________

Children: Name, Ages: ______________________

Past History of Family Illnesses or Diseases:

Relationship:__________ Illness:______________ Age:____ Living / Deceased
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Chiropractors / Nutritionists you have seen before:

Name: ______________ City __________ State _____When _______
Name: ______________ City __________ State _____When _______
Name: ______________ City __________ State _____When _______

List Medical Doctor seen within past few years:

Name: ______________ City __________ State _____When _______
Name: ______________ City __________ State _____When _______
Name: ______________ City __________ State _____When _______

Date of last physical examination:______________________

List all Surgeries / Therapies / Diseases:

Type: ______________________ When: __________
Type: ______________________ When: __________
Type: ______________________ When: __________
Type: ______________________ When: __________
Type: ______________________ When: __________

Past Accidents / Injuries / Recurrent Illnesses/ Hospitalizations:

Type: ______________________ When: _______ Hospitalized? Yes No
Type: ______________________ When: _______ Hospitalized? Yes No
Type: ______________________ When: _______ Hospitalized? Yes No

List all Medications / Birth Control/ Pain Relievers / Vitamins / Herbs you are currently taking:

Type: ______________ For: ______________ How Long: _____
Type: ______________ For: ______________ How Long: _____
Type: ______________ For: ______________ How Long: _____
Type: ______________ For: ______________ How Long: _____
Type: ______________ For: ______________ How Long: _____
Type: ______________ For: ______________ How Long: _____
Type: ______________ For: ______________ How Long: _____

Nutrition Appointment Information Form

Your Health Concern(s) in order of importance:

1. ______________________________ 2.______________________________

3. ______________________________ 4.______________________________

5. ______________________________ 6.______________________________

Do you work with any Chemicals / Metals at Work or Home: Yes / No

List: ____

On a scale 1-10 what level of stress do you experience daily? ___________

Exercise Routine: Explain: ____

How many Meals a Day do you eat?: ________

Habits: Alcohol # a week: _____ Coffee # a day: _____ Soft Drinks # a day: ____ Tea # a day: _____

Crave Salty Foods: Yes / No Crave Ice Cream: Yes / No Diet Foods: Yes / No Fast Food # a week: ______

Glasses of water a day?________________________________

How many Hours of sleep do you get a night? : ________________

Vaccination Reactions: Yes / No Explain:____

Medication Allergic Reactions: ____

Food/Environmental Allergies: ____

Do you Have Household Pets: Yes / No ____

Do you Have Farm Animals: Yes / No List animals: _______________________________

Tobacco # a day: ________ (Cigarettes Chewing tobacco Cigar Pipe)

Smoking Status: Daily Smoker, Occasional Smoker, Former Smoker, Never Smoked Start Date:_________

Dental Health: Metal Fillings: Yes / No Root Canals Yes / No Other Teeth Concerns Yes / No