New Patient Questionnaire

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ SS# _____

Home Phone _____ Cell _____ Work Phone _____

E-mail Address_____

Employer _____ Occupation _____

Spouse or Parent's Name _____ Phone _____

Emergency Contact _____ Phone _____ Relation_____

Whom may we thank for referring you to us? _____

Name of local primary physician _____ May we send a report? ☐ Yes ☐ No

Main Complaint: _____

Secondary Complaint(s): _____

Height _____ ft. _____ in. Weight _____ lbs. List drug allergies_____

Health History - Please check all that apply

☐ Anxiety	☐ Breast Lump	☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chicken Pox	☐ Chronic Fatigue
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy	☐ Fibromyalgia	☐ Fractures	☐ Glaucoma	☐ Goiter
☐ Gout	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herniated Disc	☐ Herpes	☐ High Blood Pressure	☐ High Cholesterol
☐ Kidney Disease	☐ Liver Disease	☐ Measles	☐ Migraines	☐ Miscarriage	☐ Mono	☐ M.S.	☐ Mumps
☐ Osteoporosis	☐ Parkinson's	☐ Polio	☐ Pacemaker	☐ Pneumonia	☐ Prostate	☐ Prosthesis	☐ Implants
☐ Rheumatoid	☐ Stroke	☐ Thyroid	☐ Tonsillitis	☐ Tuberculosis	☐ Tumors	☐ Typhoid	☐ Ulcers
☐ Whopping Cough	Other:						

Previous Surgeries and Dates: _____

List ALL Medications you are currently taking: _____

_____

What kind of exercise do you do? _____

What supplements do you take? _____

How much do you smoke per day? _____ Alcoholic drink per week? _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature_____ Date_____