Well Within

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____
Address _____ Apt.# _____
City _____ State_____ ZIP_____
Home Phone (____) ____-_____ Work Phone (____) ____-_____ Ext:_____
Cell Phone (____) ____-_____ E-mail:_____
Occupation _____ Employer _____

Date of Birth_____ Age _____ Marital Status: -
Height _____ Weight _____ Sex - Blood Type -_____
Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____
How important is it to you to improve your health? (circle): -
Referred by: _____

CHIEF CONCERNS (reasons you are here in order of importance)
1) _____
2)_____
3)_____
4)_____
Previous treatments for these complaints:
1)_____
2)_____
3)_____
Other concerns or problems: _____
Are you currently under the care of physicians or other health care professionals? -
Physician's names & dates of last visits: _____

Do you smoke, drink coffee, caffeinated beverages or alcohol? (if yes, how much)
Cigarettes _____ Coffee _____ Alcohol_____
Sodas _____ Tea _____ Other Caffeine _____

How can we help you feel *well within*? _____
_____

SIGNED:_____DATE: _____

Or Legal Guardian Signature:_____Date:_____