New Patient Contact and Intake: Date of Intake_____

Name_____ Date of Birth_____ Age_____ M F

Address_____

Cell Phone_____ Leave message OK? Y/N Email_____

Emergency Contact_____ Phone_____

***

Reason for visit _____Date of onset _____

Have you seen another doctor for this? Y/N _____

Other ongoing health concerns_____

_____

Medications_____

Supplements _____

Hospitalization or
Surgeries_____

Allergies: Drug_____ [ ] NKDA Food_____[ ] NKFA

Alcohol/tobacco/drugs _____ How much/often?_____

Single/Married/Divorced/Cohabit_____ yrs Children (ages)_____

Exercise _____

Occupational history _____

Place of birth/residence history_____

_____

Family Health History: please list major illness, cause of death if deceased
Mother_____

Father_____

Siblings_____

Grandparents_____