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Information Update

First Name _____ Middle Initial ___ Last Name _____

Address_____ Home Phone _____ Cell Phone _____

City _____ State ____ Zip _____ Sex M ___ F ___

Email _____ May we send your billing to this Email? Yes___No___

Birth date _____ Single ___ Married ___ Widowed ___

Patient Employed by _____ Occupation _____

Whom may we thank for referring you? _____

Insurance: Yes___No___ Policy Holder_____ Relationship _____

Emergency Contact: _____ Relationship _____ Phone _____

Have you been in an accident or had surgery since your last visit? _____

Demographics

How tall are you: _____ How much do you weigh? _____

Do you know what your blood pressure runs? _____

Do you have a dominant hand? Please circle: Right Left Ambidextrous

Allergies

Are you allergic to any medications? List allergies to medication (and your reaction to them):

☐ I have no known allergies to medication.

☐ I am allergic to: _____. My reaction is: _____

_____ _____

_____ _____

_____ _____

☐ Additional allergies to medication listed on back

Medications AND Supplements

Medications (prescribed and over the counter) as well as herbal and nutritional supports that are not correct for you can be contributing to the health problems that arise from biochemical imbalances due to poor nutrition or toxicity. Please list:

- The medications and other herbal and nutritional supports you are currently taking.
- The condition for which you are taking it.
- The dosage and frequency. If prescribed 'as needed', estimate and record the amount taken per week, month or year.
- We do need ALL of this information. If you have this information already prepared to hand to doctors, make sure the information is current, make us a copy, give it to us when you turn in this form, and write 'See attached' in the first blank.
- Place a NA in the first blank if you do not take any medications or nutritional supports.

Medications/Supplement	Taken For	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

☐ Additional medication/supplements listed on back

Tobacco:

Never Used Tobacco:

- ☐ Never used tobacco in any form

Ex-User:

- ☐ Ex-very heavy cigarette smoker (40+/day)
- ☐ Ex-heavy cigarette smoker (20-39/day)
- ☐ Ex-moderate cigarette smoker (10-19/day)
- ☐ Ex-light cigarette smoker (1-9/day)
- ☐ Ex-trivial cigarette smoker (<1/day)
- ☐ Ex-pipe smoker
- ☐ Ex-cigar smoker
- ☐ Ex-user tobacco as chew or snuff

Tobacco User:

- ☐ Chews fine cut tobacco Chews loose leaf tobacco
- ☐ Chews plug tobacco
- ☐ Chews products containing tobacco
- ☐ Chews twist tobacco
- ☐ Snuff user

Smoker:

- ☐ Chain smoker
- ☐ Very heavy cigarette smoker (40+ cigs/day)
- ☐ Heavy cigarette smoker (20-39 cigs/day)
- ☐ Moderate cigarette smoker (10-19 cigs/day)
- ☐ Light cigarette smoker (1-9 cigs/day)
- ☐ Trivial cigarette smoker (less than one cigarette/day)
- ☐ Pipe smoker
- ☐ Cigar Smoker

Started using tobacco in: _____ Stopped using tobacco in: _____

Who is your primary care physician? _____ Phone #: _____

When was your last physical? _____

_____ _____ _____

Patient Signature (18 + years) Patient Printed Name Today's Date

_____ _____ _____

Guardian Signature (under 18 years) Guardian Printed Name Today's Date