PATIENT INTAKE FORM

Please take the time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Name: _____

Date: _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email:_____ (Please note: We use email for informational purposes only. Ex monthly newsletters, important updates and allergy alerts.

Date of Birth (dd-mm-yyyy): _____ Age: _____

Referred by: _____

Physician: _____

Emergency Contact: _____ Phone #:_____

MAIN COMPLAINT (symptoms, diagnosis, duration, etc) :

SIGNIFICANT TRAUMA (physical):

SURGERIES (Please include date of procedure):

KNOWN ALLERGIES (chemical, environmental, food, drug, ect.):

VITAMINS, SUPPLEMENTS, HERBS, MEDICATIONS: