DC Healthy Living Center

New Patient Information Form- e-mail version

Please print clearly

Name. ______________________ Date ________
Address ______________________ Apt # ________
City ______________________ State ______ Zip ________
Shipping address ______________________

Home phone ______________________ work phone ________
e-mail address ______________________ Cell phone ________
Referred by: ______________________
Occupation ______________________ Employer ________
Date of birth ______________________ Height ______ Weight ________
Overall health: Indicate Excellent/Good/Fair/Poor/Other: ________
Chief complaint: ______________________

Previous treatment for this complaint: ______________________

Other complaints or problems: ______________________

Current medications being taken: ______________________

Are you currently under the care of a physician or other health care professionals?
If yes, please give name and date of last visit ______________________

What supplements are you taking? ______________________

Indicate how much you smoke, drink coffee and/or alcohol Alcohol ________
Cigarettes ______________________ Coffee ________

Marital Status: ______________________ Name of Spouse: ________
Describe health of spouse: ______________________ Number of children if any: ________
Name of child: Age Sex:M/F Any physical conditions or concerns?

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other:

What can we do to make you happier? ______________________

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HISTORY:

List any major illnesses (with approximate dates): ______________________

List any surgeries or operations with approximate dates:

Past accidents/injuries ______________________

	Day 1	Day 2
Breakfast		
Snacks		
Lunch		
Snacks		
Dinner		
Snacks		

Signed: ______________________ Date: __________

Office Use Only

Ht: Wt: % of Ideal Wt: Body Fat %:

BP: Pulse: BMI: Resp: