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NEW PATIENT INFORMATION FORM

Name _____ Date _____

Address _____

Postcode _____ Telephone (Mobile) _____ (Home) _____

Work Address _____

_____ Telephone (Work) _____

Email Address _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason why you are here) _____

_____

Previous treatments for this complaint _____

_____

Other complaints or problems _____

_____

Current medication/drugs _____

_____

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

_____

Nutritional supplements _____

Do you smoke, drink coffee or alcohol? Cigarettes _____ Coffee _____ Alcohol _____

HISTORY:

List any major illnesses with approximate dates _____
_____

List any surgery or operations with approximate dates _____
_____

Past accidents or injuries: _____
_____

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Marital Status: S M D Name of Spouse: _____

Describe health of spouse: _____ No. of children: _____

Name of child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

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

What can we do to make you happier? _____
_____

SIGNED: _____ DATE: _____