



PATIENT INFORMATION

General Information

Welcome to our office. To better help us evaluate you, please complete the following form. If you have any questions, we will be happy to help you. Thank you!

DATE _____

NAME _____

ADDRESS _____

HOME # _____

WORK # _____

CELL # _____

OTHER # _____

WHEN IS A GOOD TIME TO CALL? _____

E-MAIL ADDRESS _____

MARITAL STATUS _____ BIRTHDATE _____

HEIGHT _____ WEIGHT _____ AGE _____

OCCUPATION _____

SS# _____

HOW DID YOU HEAR ABOUT US? Please be specific.

Friend/Family _____

Physician's Office _____

Internet--Which website? _____

Other _____

I verify that the above is an accurate representation of my past and current health.

HIPPA ACKNOWLEDGEMENT: I also verify that I have received a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

Patient Signature _____ Date _____

Medical History

Primary Care Physician: _____

List all Medications: _____

List any surgeries you have had and date performed: _____

Do you have any allergies: ___ Yes ___ No

Do you use: Tobacco ___ Yes ___ No Alcohol ___ Yes ___ No

Past Medical History: _____

Family History: _____

Please circle which best describes you:

1. Sleep less than 5hrs/night 5-8 hours/night 8 hours or more/night

2. Stress 0 1 2 3
 No Stress Seldom Stress Frequent Stress Always Stressed

If circled "2" or "3" please explain: _____

3. Exercise Yes No

If yes, please explain: _____

Is there any other information you would like us to be aware of?
