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New Patient Questionnaire

Name:_____ Date:_____

Address: _____

Tel (home): _____ (work):_____

Cell:_____

Email Address:_____

Age:_____ Date of Birth:_____/_____/_____ Gender: Male / Female

Occupation:_____Employer:_____

How did you hear about our clinic? _____

Other Health Care Providers:

Name:_____

Name:_____

What are your most important health problems? (In order of importance)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

General

Height: _____ Weight: _____ lbs. Weight 1 year ago:_____ lbs.

Maximum Weight: _____ lbs. When? _____

When during the day is your energy best? _____ Worst? _____

Family History

_____

_____

_____

_____

Hospitalization

What hospitalizations, surgeries, X-rays, CAT Scans, EEG, EKG's have you had?

_____Year_____ _____Year_____

_____Year_____ _____Year_____

_____Year_____ _____Year_____

Allergies

Are you hypersensitive or allergic to…

Any drugs? _____

Any foods? _____

Any environmental/chemicals? _____

Current Medications

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Habits

Main interests and hobbies: _____

Do you exercise? Yes/No
If yes what kind? _____ How often? _____

Average 6-8 hrs of sleep? Y/N

Sleep well? Y/N

Awaken rested? Y/N

Have a supportive relationship? Y/N

Have a history of abuse? Y/N

Any major traumas? Y/N

Use recreational drugs? Y/N

Been treated for drug dependence? Y/N

Use alcoholic beverages? Y/N

Treated for alcoholism? Y/N

Do you use tobacco? Y/N

Smoked previously? Y/N

If so how many years?_____

How many packs per day? _____

Enjoy your work? Y/N

Take vacations? Y/N

Spend time outside? Y/N

Watch television? Y/N

How many hours? _____ day/week

Read? Y/N

How many hours? _____ day/week

Do you eat 3 meals per day? Y/N

Do you go on diets often? Y/N

Do you eat out often? Y/N

Do you drink coffee? Y/N

Drink black/green tea? Y/N

Do you drink cola/soda? Y/N

Do you eat refined sugar? Y/N

Do you add salt? Y/N

Is there anything else you would like to add or comment on?

_____

_____

_____