Optimal Wellness Natural Health Center

New Patient Information Form

Please Print Clearly:

Name _____ Date _____

Address_____ Apt.#_____

City_____ State_____ ZIP_____

Shipping Address_____

_____

Home Phone (_____) _____ Work phone (_____) _____

REFERRED BY: _____

Occupation_____. Employer _____

Date of Birth_____ Age_____ Sex: M/F. Height____ Weight_____

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

Previous treatments for this complaint_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Current medications / drugs being taken: (use separate sheet if needed):

_____

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 you are taking_____

Do you smoke, drink coffees or alcohol? (if yes, indicate how much)

Cigarettes_____Coffee_____Alcohol_____

HISTORY.

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date: _____

_____

Past accidents or injuries: _____

_____

Marital Status: S M D W. Name of Spouse _____

Describe health of spouse_____ Number of children_____

Name of Child	Age	Sex	Any physical condition or concerns?

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

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

SIGNED: _____DATE: _____