

## 1. Patient Information

Date \_\_\_\_\_ Patient Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Birthdate: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### IN CASE OF EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### MEDICAL HISTORY

Date of last physical examination \_\_\_\_\_ Physician's Name \_\_\_\_\_

Medicine/Vitamin & Herbal Supplements(s) you are currently taking \_\_\_\_\_

Are you allergic to any medications/substances? *Please* List \_\_\_\_\_

What is your reason for this visit? \_\_\_\_\_

*Patient Complete Reverse Side =>*

(For Office Use) DIET: \_\_\_\_\_ DATE: \_\_\_\_\_

HERBS (ENGLISH) : AM \_\_\_\_\_ MID \_\_\_\_\_ PM \_\_\_\_\_