

NEW CLIENT REGISTRATION

Name: _____ Age: _____ Birthdate: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____ Email: _____

Occupation: _____

Marital status: _____

How did you hear about this office: _____

Name of family doctor or clinic: _____

If the patient is a child, please indicate the following:

Mother's Name: _____ Child lives with you? _____

Father's Name: _____ Child lives with you? _____

What vaccinations has the child taken? _____

YOUR HEALTH HISTORY:

What medications do you currently take? _____

What medications have you taken in the past? _____

Have you had any of the previous illnesses? (Please indicate the diagnosis and when it occurred)

Autoimmune disease

Cancer

Heart Disease

High blood pressure

Diabetes

Mental illness

Neurological disorders

Pneumonia

Tuberculosis

Venereal diseases

Please write any other conditions you suffer from.

Any surgeries or hospitalizations: