1171 NE Cleveland Street • Clearwater, FL 33755 • 727-447-6442

NEW PATIENT INFORMATION FORM

Please print clearly:

Name:____ Date:_________________
Address:____
City:____State:______ZIP:_____________

Primary Phone:____________________________________Please Circle (mobile/home/work/other)

Secondary Phone: _________________________________Please Circle (mobile /home/work/other)

Tertiary Phone: __________________________________Please Circle (mobile /home/work/other)

E-mail address: ____

Date of Birth:________________ Age: ______ Gender: M/F Height:_____ Weight: ________

HOW DID YOU HEAR ABOUT US?____

Occupation___________________________Employer__________________________________

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

Chief complaint (reason you are here): (use back of sheet if more room needed)

What would be the personal benefit to having the above health situation handled?

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 coffee or alcohol? (if yes indicate how much)

Cigarettes Coffee Alcohol

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 Significant Other:____

Describe their health:

Number of children, if any:

Name of Child	Age	Gender	Any health situations/concerns?

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

What can we do to make you happier?

If we were to do media promotions, which source would you most likely to see them? (circle all that apply)

Facebook	Instagram	Text	Email
Bulletin Boards	Mailed Letters	Mailed Postcards	Other______________

The above is true to the best of my knowledge:

_______________________________ _______________________________________ ____________

Print (Patient Name) Patient Signature *(Parent/Guardian, if under 18)* Date