Nutritional Wellness Initiative, LLC

New Patient Information Form

Please Print Clearly. Use back side of page if needed for any questions

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Email Address _____

Referred By _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex M F Height _____ Weight _____

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

Chief Complaint (reason you are here):

_____

_____

Previous Treatments for this complaint:

_____

_____

Other complains or problems:

_____

_____

Current medications/drugs/nutritional supplements being taken:

_____

_____

Are you currently under the care of a physician or other health care professionals? If so, please give name and date of last visit: _____

Do you smoke, drink coffee or alcohol? If so, please indicate how much.

Cigarettes _____ Coffee _____ Alcohol _____

List any major illnesses, surgery or operations with the approximate dates:

_____

Past accidents or injuries: _____

Marital Status: S M D W Name of Spouse _____ # of Children _____

Describe health of Spouse

Name of Child	Age	Sex	Any Physical conditions or concerns?

Any family history of serious illnesses? (circle those which apply)

Cancer Diabetes Heart Other _____

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

_____

Signed: _____ Date: _____