BREAKTHROUGH HEALTHCARE

NEW PATIENT INFORMATION FORM

Please print clearly:

Name ____ Date ____/____/________

Address____ Apt. # ________________

City ________________________________ State____________ Zip ____________________

Shipping address (if different from mailing address) ____________________________________

____

Home phone (____) _____-________ Work phone (____) _____-_______

REFERRED BY __________________________ Email Address ______________________________

Occupation ______________________________ Employer ________________________________

Date of Birth ______________________ Sex M / F Height _____________ weight ___________lbs

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

Chief Complaint (reason you are here) ____

____

Previous treatment for this complaint ____

____

Other complaints or problems ____

Current medications/drugs being taken ____

____

Are you currently under the care of a physician or other health care professional? YES / NO

(If yes, please give the name and the date of last visit) _________________________________

Nutritional supplements you are taking ____

____

Do you smoke, drink coffee, or alcohol? (If yes, include how much)

Cigarettes ______________________ Coffee ______________________ Alcohol ________________

____

Office use only

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Please print clearly:

Name ____ Date ____/____/________

HISTORY:

List any major illnesses (with approx. dates) ________________________________

____

List any surgeries (with approx. dates) ________________________________

____

Past Accidents or injuries ________________________________

____

Marital Status S M D W Name of spouse ________________________________

Describe health of Spouse ________________________Number of children (if any) ________

Name of Child	Age	Sex	Any health concerns list here
____________________	_____	M / F	____________________
____________________	_____	M / F	____________________
____________________	_____	M / F	____________________
____________________	_____	M / F	____________________

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

____

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

____

What can we do to make you happier healthwise? ________________________________

____

SIGNED ____ DATE ____/____/__________