New Patient Health History

Today's Date / / **Signature of Patient** _____

Name _____ **Nick Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Mobile Phone** _____

Email _____

By providing my email address, I authorize my doctor to contact me via the email address provided

Preferred Contact Method *(check one)* ❑ Primary Phone ❑ Mobile Phone ❑ Email

Date of Birth / / **Age** _____ **Sex at birth:** ❑ Male ❑ Female ❑ Prefer not to answer

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Current medications, include frequency and dosage if known. If no medications, check here: ❑

_____

_____

_____

List any known *medication* allergies you have. If no allergies are known, check here: ❑

_____

What brings you in today? _____

_____

To be performed by clinic staff:

Onset Date: _____ **VAS:** _____ / 10

C	ROM	L
	F	
	E	
	LLF	
	RLF	
	LR	
	RR