WEXFORD CHIROPRACTIC CENTRE

NUTRITION RESPONSE TESTING

NEW PATIENT INFORMATION FORM

Please Print Clearly:

Name_____ **Date**_____

Address_____ **Apt.#**_____

City_____ **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 – Use a separate sheet if more room needed)_____

_____

Previous treatments for this complaint?_____

_____

Other complaints or problems?_____

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

_____

Nutritional supplements you are taking_____

_____

Do you smoke, drink coffee or alcohol? If yes indicate how much:_____

Cigarettes_____ **Coffee**_____ **Alchohol**_____

Name_____ **Date**_____

HISTORY:

List any major illnesses (with approx. dates)_____

_____

List any surgery or operations with approx. dates:_____

Past accidents or injuries_____

_____

Marital Status: S M D W Name of Spouse_____

Describe the health of spouse: _____

Number of Children if any: _____

Name of Child	**Age**	**Sex**	**Any physical conditions or concerns?**

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

Other_____

Any household pets or other animals you or family members are in close contact with?_____

_____

What can we do to make you happier?_____

_____

Signed:_____ **Date**_____