

Union Square Wellness Center
NEW PATIENT INFORMATION FORM

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Please print clearly:

Name _____ Date _____
Address _____ Apt.# _____
City _____ State _____ ZIP _____
Shipping Address _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____

E-mail address: _____

Preferred way to contact you to confirm appt. – circle one Home, Cell, Work or Email

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 separate sheet if more room needed)

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 _____

Office Use Only:

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Name: _____ Date _____

HISTORY:

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 Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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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 _____