

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Number:** \_\_\_\_\_

\_\_\_\_\_

**Work Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

Would you like to receive my e-newsletter? \_\_\_\_\_

**Current Healthcare Providers:** (M.D. , N.D. , Chiropractor , Massage Therapist , etc)

Name	Name	Name
Address	Address	Address
Phone Number	Phone Number	Phone Number
Type of Provider	Type of Provider	Type of Provider

**Medications and Supplements:**


**KNOWN ALLERGIES:** \_\_\_\_\_

**Past and Present Illnesses, Diseases, Surgeries, Hospitalizations:**


**Family Medical History** (high blood pressure, diabetes, cancer, etc):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Reason for Today's Visit:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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