# High Point Health

## NEW PATIENT INFORMATION FORM

Page 1 front

Please print clearly:

Name_______________________________________ Date ___________

Address _____________________________________ Apt.# __________

City_________________________ State__________ ZIP ____________

Shipping Address ______________________________________________

___________________________________________________________

Home Phone (____) ____-_________ Work Phone (____) ____-_________

e-mail 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 - the reason you are here): (use bottom of back page 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 ____________

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Page 1 back

Name: ______________________________________ Date ___________

HISTORY:

List any major illnesses (with approx. dates): ______________________

____________________________________________________________

List any surgery or operations with approx. date: ___________________

____________________________________________________________

Past Accidents or injuries: ______________________________________

____________________________________________________________

____________________________________________________________

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Marital Status: S M D W O Name of Partner _____________

Describe health of partner: _______________ Number of children if any ___

| Name of Child | Age | Sex | Any physical conditions or concerns? |
|---|---|---|---|
| _____________________ | ___ | M/F | ___________________________ |
| _____________________ | ___ | M/F | ___________________________ |
| _____________________ | ___ | M/F | ___________________________ |

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__________