BREAKTHROUGH HEALTHCARE

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date ____/____/_____

Address_____ Apt. # _____

City _____ State_____ Zip _____

Shipping address (if different from mailing address) _____

_____

Home phone (____) _____-_____ Work phone (____) _____-_____

REFERRED BY _____ Email Address _____

Occupation _____ Employer _____

Date of Birth _____ Sex M / F Height _____ weight _____lbs

Overall health (circle one) Excellent / Good / Fair / Poor / Other: _____

Chief Complaint (reason you are here) _____

_____

Previous treatment for this complaint _____

_____

Other complaints or problems _____

Current medications/drugs being taken _____

_____

Are you currently under the care of a physician or other health care professional? YES / NO

(If yes, please give the name and the date of last visit) _____

Nutritional supplements you are taking _____

_____

Do you smoke, drink coffee, or alcohol? (If yes, include how much)

Cigarettes _____ Coffee _____ Alcohol _____

_____

Office use only