Cultural Chiropractic, P.A.
Natural Health Improvement Center

NUTRITION PATIENT INFORMATION FORM

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 (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_____________

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Office Use Only:

Cultural Chiropractic, P.A.
Natural Health Improvement Center

NUTRITION PATIENT INFORMATION FORM

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 Name of Spouse ______________________________

Describe health of spouse: _______________________ 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 ____________