Chagrin Natural Health Clinic
NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address _____

_____

Home Phone: (____) _____-_____

Cell 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 _____

==========

Office Use Only:

Chagrin Natural Health Clinic
NEW 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: _____

_____

==========

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?_____

_____

I clearly understand and agree that I am choosing to receive care and treatment at Holistic Visionary Inc. under my own free will. I also clearly understand and agree that Holistic Visionary Inc. does not claim to cure or prevent any disease. I authorize release of any medical information necessary to help my condition. I understand that I am personally responsible for payment on the date that services are rendered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. We kindly require 24 hours notice for all cancelled appointments.

We do not accept insurance or offer insurance billing codes for our services. We do provide a general receipt with services rendered if requested.

PATIENT'S SIGNATURE_____ DATE_____

SPOUSE'S OR GUARDIAN'S SIGNATURE_____ DATE_____