

DEMOGRAPHIC/MEDICAL INFORMATION FORM

Name: _____ Age: _____ DOB: _____ Date: ____/____/____

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Address _____ **City** _____ **State** ____ **Zip** _____
Home Tel.# _____ **Work Tel.#** _____ **Cell Tel.#** _____
Marital Status: [single] [married] [widowed ____/____/____] _____
Specifically, how did you find us? (required) _____
Emergency Contact: Name _____ Phone # _____ Relationship _____
Occupation: [retired] [active] _____
Have you ever used illicit or recreational drugs? [no] [yes] ⇒ If yes, what type and how often? _____
Are you currently using [no] [yes] _____
Do you drink alcohol [no] [yes] ⇒ oz's per day _____
Do you smoke cigarettes [no] [yes] ⇒ how much _____ if stopped, when? _____

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Surgery [no] [yes] ⇒ dates and reasons for surgery: _____

Medications and supplements (please include names and dosages) use additional sheets if needed

Do you have any allergies/reactions to medications: [no] [yes] (please list the medications if yes)

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FAMILY HISTORY (immediate family members): (please state who if yes)

Diabetes [no][yes] _____ Cancer [no][yes] _____

Hypertension [no][yes] _____ Thyroid [no][yes] _____

Heart disease [no][yes] _____ Stroke [no][yes] _____

Other diseases _____

Signature: _____ Date _____
