NEW PATIENT DATA

PLEASE PRINT

PATIENT INFORMATION

Full Name (include middle) _____

Date of Birth _____ Age _____ Sex M_____ F_____

Name of parent or guardian (if patient is a minor) _____

Relationship of patient and guardian _____

Home Address _____

City, State, Zip _____

Home Phone _____ Cell _____ Work _____

Email Address _____

Employer _____ Occupation _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Number of Children: Boys _____ Girls _____

Name of Spouse _____

Spouse's Employer _____ Occupation _____

EMERGENCY INFORMATION

Contact in Emergency _____ Relationship _____

Phone _____

Nearest relative not living with you _____ Phone _____

Nearest friend not living with you _____ Phone _____

How did you hear about us? Referred by _____

REASON FOR FIRST VISIT

Chief complaint, please describe fully _____

_____

_____

_____

Duration of present condition _____

What do you believe caused this condition? _____

_____

Diagnosis by your doctor (if available) _____

_____

Dental History:

Have you had, or do you have:

Braces _____ Bridges _____ Cavities _____

Gum Work _____ Oral Surgeries _____ Root Canals _____

Teeth Replaced _____ TMJ Problems _____

Fillings _____ If yes, at what age did you first get fillings? _____

Any fillings taken out _____

Crowns _____ If yes, what are they made of (procelain / gold/ etc)? _____

Other information _____

_____

Present / Past History:

Any history of **anaphylactic** reactions? _____

If yes, what did you react to? _____

_____

Have you been allergy tested? _____ List any **known allergies** _____

_____

List all foods and beverages you **crave** (or eat more than 3 times weekly): _____

_____

_____

Have you or do you now have any **Pets**? _____ Kind? _____

Have you had any **tick bites** or reaction to **insects**? _____

Have you **traveled** to other countries? (Names) _____

Have you ever had **food poisoning**? _____

Do you have a **swamp cooler** of **refrigerated air**? _____

Have you or are you now, living near or on a **farm** or near **crop spraying**? _____

Have you or are you now, living near **microwave towers** or **toxic dumps**? _____

Do you take **vitamins**? _____ List names: _____ _____

_____ _____ _____

_____ _____ _____

List any **medications** you are taking now: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you taken any **casual drugs** now or in the past? _____ If yes how many years and what kind(s)? _____

Have you ever **smoked**? _____ How many per day? _____ Currently smoke? _____

Do you drink **alcohol**? _____ regularly _____ seldom _____ # per day _____

Do you drink **coffee**? _____ How much? _____

Do you **exercise**? _____ regularly _____ seldom _____ type? _____

Hobbies (if any): _____

Exposure to environmental **toxic substances** through employment, hobbies, etc.? _____

_____

List any **hospitalization**(s): _____

_____

_____

Have you had any previous/current **back troubles**? _____ Describe _____

_____

_____

Any aggressive behaviors/ depression/ emotional imbalances, past or present: _____

_____

Other _____

_____

Physical Trauma:

Have you had any:

Birth trauma _____ Bicycle falls/accidents _____ Car accidents _____

Head trauma _____ Highchair falls _____ Hit by any balls _____

Monkey-bars fall _____ Skateboarding falls _____ Tree falls _____

Other (List any other trauma/ significant injuries as is slips, falls, any fall involving the head, etc)?

Please explain: _____

_____

_____

Vaccination History:

Were you vaccinated as a child? _____ If yes, which vaccines have you had:

MMR (Measles, Mumps, Rubella) _____

Polio Vaccine _____ DtaP _____ Hib Vaccine _____ HBV _____

Varicella Vaccine _____ PCV7 _____ Diphtheria _____ DPT _____

Infuenza _____

Other _____

Vaccination reaction(s)? _____

_____

(Please include a copy of vaccination records, if possible)

Personal History

Childhood Information & Past History: (please check or specify as appropriate)

Abdominal pain _____ ADD/ADHD _____ Alcoholism _____
Allergies _____ Allergy Shots _____ Anemia _____
Anorexia _____ Appendicitis _____ Arthritis _____
Asthma _____ Autism _____ Bleeding disorder _____
Blood clots _____ Breast lumps _____ Blood pressure: high____ low____
Bronchitis _____ Bulimia _____ Cancer _____
Cataracts _____ Chemical dependency _____
Chicken Pox _____ Cholesterol: high ____low____ Chronic fatigue _____
Colic _____ Congenital problems _____ Dental problems _____
Deviated Septum _____ Diabetes _____ Diverticulitis _____
Dyslexia _____ Ear aches _____ Emphysema _____
Epilepsy _____ Fatigue _____ Food sensitivity _____
Fractures _____ Glaucoma _____ Goiter _____
Gout _____ Hay fever _____ Headaches _____
Hernia _____ Herniated Disc _____ Herpes _____
High temps _____ HIV (Aids) _____ Hyper activity _____
Hypertension _____ Hypoglycemia _____ Irritable Bowel _____
Kidney disease _____ Learning differences _____ Liver disease _____
Lung disease _____ Lyme disease _____ Measles _____
Migraine headaches _____ Miscarriage _____ Mononucleosis _____
Mental/Emotional problems _____ Multiple Sclerosis _____
Osteoporosis _____ Mumps _____ Nervous Breakdown _____
Pacemaker _____ Parkinson's disease _____ Pinched nerve _____
Polio _____ Pneumonia _____ Prostrate problems _____
Psychiatric care _____ Rheumatic Fever _____ Rheumatoid Arthritis _____
RSV _____ Scarlet Fever _____ Sexual problems _____
Skin Dermatitis _____ Strep _____ Stroke _____
Thyroid problems _____ Tonsillitis _____ Tuberculosis _____
Tumor growths _____ Ulcers _____ Weight: over____ under____
Whooping Cough _____

List any significant illness: _____

_____

Any unusual diseases? _____

List any surgeries or operations: _____

_____