Rapha Wellness Center
New 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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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: _____

Household pets or other animals you or family members are in close contact with: _____

_____

What can we do to make you happier?: _____

_____

SIGNED: _____ Date: _____

Office Use Only: