

Willow Bend Chiropractic

5930 W. Park Blvd. Ste. 500 * Plano, TX 75093 * (972) 267-5998

NUTRITIONAL NEW PATIENT INFORMATION

Patient Name: _____ Date: ____/____/____

Date of Birth: ____/____/____ Age: _____ Sex: (Male / Female) Height: _____ Weight: _____

Marital Status: Single / Married / Divorced Name of Spouse: _____

Occupation: _____ E-mail: _____

Any household pets or other animals that you are in close contact with? _____

You would rate your overall health as (please circle): Excellent / Fair / Poor / Other _____

What can we do to make you happier? _____

REASON FOR CURRENT VISIT

Chief Complaint (reason you are here): _____

Previous Treatments for this Complaint: _____

Please List Other Issues or Problems: _____

Are you currently under the care of a health care professional for this issue? _____ (Approximate Last Visit Date: _____)

HEALTH HISTORY

List Major Illnesses (with approximate dates): _____

Past Accidents, Falls, or Sports Injuries (with approximate dates): _____

Past Surgeries or Medical Procedures (with approximate dates): _____

Check the Following Items which Apply to You and Indicate the Amount :

Coffee _____ Artificial Sweetener _____ Ice Cream _____

Tea _____ Antacids _____ Alcohol _____

Soft Drinks _____ Laxatives _____ Cigarettes _____

Diet Drinks _____ Candy _____ Other Tobacco _____

How many desserts do you have in an average week? _____

Please List Any Medications You are Taking: _____

Please List Any Vitamins, Herbs, or Supplements You are Taking: _____

