Donnelly Chiropractic

NUTRITION – NEW PATIENT INTERVIEW

Please print clearly:

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ E-mail _____

Personal phone (_____) _____ - _____ Work phone (_____) _____ - _____

Marital status: S M D W Emergency Contact _____

Whom may we thank for referring you? _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex: M F Height _____ Weight _____

How would you describe your overall health (circle one): Excellent Good Fair Poor Other_____

What is your chief complaint (reason you are here): _____

List any previous treatments for this complaint: _____

List ALL health problems (most severe first): _____

_____

Are you currently under the care of a physician or other health care professionals? If yes, please give name and date of last visit: _____

List current medications/drugs being taken: _____

_____

List nutritional/herbal supplements or homeopathics you are taking: _____

_____

List any allergies you may have: _____

Please indicate how much and how often you consume the following: Ice cream _____

Chocolate _____ Popcorn _____ Pastries _____

Soda _____ Spicy foods _____ Shellfish _____ Coffee _____ Alcohol _____ Tobacco _____

How much water do you consume each day? _____ From what source: Bottled / City / Well

Confidential – Have you ever used recreational drugs? Y N

Do you have any breast implants or prosthesis? Y N

Are you having any digestive issues? _____

How often do you have bowel movements? _____

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Do you have any issues with urination or bladder control? _____

Women – Are you pregnant? Y N Nursing? Y N

Past or current birth control use? Y N How long? _____

Are you having any menstrual or menopausal issues? _____

_____

HEALTH HISTORY:

List any major illnesses (with approx. dates), including chronic health issues which may have resolved:

_____

_____

_____

List any surgery or operations (with approx. dates): _____

_____

List any past accidents or injuries: _____

_____

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Describe the health of your spouse _____ Number of children, if any _____

Childs' Age	Sex	Any physical conditions or concerns?
_____	M F	_____
_____	M F	_____
_____	M F	_____

Do(Have) your siblings, parents, or grandparents have(had) any of the following: Cancer / Diabetes / Heart Issues / Depression / Alcoholism / Other

Please specify which relative, their age, and age of disease onset _____

_____

Do you have any pets or other animals you or your family comes in close contact with? _____

What can we do to make you happier? _____

SIGNED: _____ DATE: _____

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Office Use Only: