**Date:**

## Contact Information

First Name: MI:

Last Name:

Address:

City:

State/Prov: Zip/Postal Code:

Phone:

Cell Phone:

eMail:

Work Phone:

## Identification

Age: Birth Date:

Height: Weight:

Gender: ☐ F ☐ M

Ethnicity:

Status: ☐ Married/Partner ☐ Single

Occupation:

Employer:

Employer Phone:

## Primary Physician

Name:

Clinic name:

Address:

City:

State/Prov: Zip/Postal Code:

Phone:

## Emergency Contact

Name:

Relationship:

Address:

City:

State/Prov: Zip/Postal Code:

Cell Phone:

eMail:

Phone/Daytime:

Phone/Evening:

## Note / Comment

## Current Medications

List all current medications, supplements and herbs, and reason for taking each:

## Surgeries and Injuries

List any surgeries, include dates:

List any serious injuries, include dates:

## Serious Illness

List any serious illnesses, include dates:

List any long-term or persistent condition, include date condition began:

## Pain

Indicate area(s) of pain: