



NEW CLIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____
Address _____ Apt.# _____
City _____ State _____ ZIP _____
Shipping Address _____

Home Phone (____) ____ - _____ Work Phone (____) ____ - _____
Cell 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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Office Use Only:

Covenant Natural Health Care

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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	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

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

SIGNED: _____ DATE _____