



NEW PATIENT INFORMATION FORM

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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 _____

=====

Office Use Only:



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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: _____

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 _____

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

What can we do to make you happier? _____

SIGNED: _____ DATE _____



The Spring
center for natural medicine

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Patient Name:

Date:

1. Chief Concerns:

2. Medications and/or Nutritional Supplements currently on:



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3. Dietary Intake for 2 days before appointment:

Breakfast:

Breakfast:

Snacks:

Snacks:

Lunch:

Lunch:

Snacks:

Snacks:

Dinner:

Dinner:

Snacks:

Snacks: