Energy Healing Systems, Inc.

NEW PATIENT INFORMATION FORM- FAX VERSION

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 ______________

===

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? ______________________________

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NEW PATIENT INFORMATION FORM

Name: ____ Date ____________________

HISTORY:
List any major illnesses (with approx. dates): ____
____
List any surgery or operations with approx. date:_______________________________________
____
Past Accidents or injuries: ____
____
==

Dietary Intake for Two Days Before Appointment:

Day 1	**Day 2**
Breakfast	Breakfast
Snacks	Snacks
Lunch	Lunch
Snacks	Snacks
Dinner	Dinner
Snacks	Snacks

SIGNED:____ DATE __________________
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Office Use Only:

Ht:	Wt:	% of Ideal Wt:	Body Fat %
BP:	Pulse:	BMI:	Resp:

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