Aloha WELLNESS

NUTRITION NEW PATIENT INFORMATION

Patient Data

First Name _____ **Last Name** _____ **Date** _____

Street Address _____

City _____ **State** ___ **Zip** _____ **Referred BY** _____

Cell _____ **Work** _____ **Home** _____

Email _____

*(Your email will **NOT** be shared with any 3rd parties and is used for occasional office announcements and promotions.)*

Personal History

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 additional sheet if needed) _____

_____

Previous treatments for this complaint _____

Other Complaints or Problems (use additional sheet if needed) _____

_____

What medications are you taking and for what conditions? (Please list dosage and amounts, etc.)

_____

Are you currently under the care of physician or other health care professional? **No** **Yes**

(If yes, please provide name and date of last visit) _____

_____

What vitamins, minerals, or herbs do you take? (Please list conditions, dosage, and frequency)

_____

Habits - How Much?	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐
Bread/Pasta	☐	☐	☐	☐
Fast Foods	☐	☐	☐	☐

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Name: _____ **Date:** _____

Medical History

List any major illnesses (with approx. dates) _____
_____

List any surgery or operations (with approx. date) _____
_____

List past major accidents or injuries (with approx. dates) _____
_____

Family History

Marital Status: S M D W **Spouse's Name**_____

Spouse's Health Status _____ **Number of Children** _____

Name of Child	Age	Sex	Any physical conditions or concerns?
		M / F	
		M / F	
		M / F	

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

Any household pets or other animals that you or your family are in close contact
_____

Signatures

What can we do to make you happier? _____
_____
_____

I hereby authorize the Doctor to examine and treat my conditions as he deems appropriate through the use of Nutrition Response Testing, and I give authority for these procedures to be performed. The Doctor will not be held responsible for any pre-existing diagnosed conditions nor for any medical diagnosis.

The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's signature _____ **Date** _____
Spouse's/Guardian's signature _____ **Date** _____

Office Use Only: