

AcuNatural Family Healthcare ~ Paul J. Rosen, J.D., L.Ac.

306 East 37th Street ~ Vancouver, WA 98663 ~ Tel: (360) 750-7375 ~ Fax: (360) 750-8602

NEW CLIENT INFORMATION FORM

Page 2 of 2

Name: _____ Date _____

HISTORY:

List any major illnesses with approx. dates: _____

List any surgeries or operations with approx. dates: _____

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	_____

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 _____

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Page 1 of 2

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 _____

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Office Use Only: