CLINICAL RECORD FORM

ADMINISTRATIVE & SELF-REPORT INFORMATION **(*May Be Completed by Patient*)**

Patient: _____ Date of Birth: ___/___/___ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Cell (____) _____Home: (____) _____Email: (___) _____

Health Plan or other Patient ID#: _____ SS#: _____

Employer/School: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Widowed

Emergency Contact: _____ Telephone: (____) _____

Parent/Guardian (if relevant): Name: _____

Address: _____ Telephone: (____) _____

Current Medical Conditions:_____

_____

_____

_____

_____

_____

Current Medications, Herbal Supplements & Vitamins (Daily Dose, Start Date, Name of Prescriber): _____

_____

_____

_____

_____

Allergies/Adverse Reactions to Treatment:_____

_____

_____

Primary Care Physician Name: _____

Address: _____ Telephone: (____) _____

Reason for Seeking Evaluation Today: _____

_____

_____

_____

_____

Patient Signature: _____ Date: _____