# New Patient


| | | |
|---|---|---|
| First Name: | Last Name: | Male/Female: |
| Address: | | |
| City: | State: | Zip: |
| Phone: | | |
| Email: | | |
| Date of Birth: | Age: | |
| Marital Status: | | |
| Emergency Contact: | Relationship: | Phone: |
| Referred by: | | |

Please describe the main reason for your visit today:

Please indicate if you have any of the following:

- ☐ Cardiac pacemaker
- ☐ Seizure disorder
- ☐ Bleeding disorder/ Blood thinners
- ☐ Fainting disorders
- ☐ High blood pressure
- ☐ Believe you are or may be pregnant
- ☐ HIV/AIDS positive
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Other: _____

List all major childhood and adult illnesses:

Have you had any surgeries, major accidents or injuries, please explain:

WASHIZU
body wellness

List all medications or supplements, including herbs and vitamins you are currently taking:

_____

_____

Occupation: _____

Do you have a regular exercise program? Please describe.

_____

_____

Are you on a restricted diet? What kind?

_____

How much sugar/dessert do you eat per week? _____

How much dairy do you eat per week? _____

How many packs of cigarettes do you smoke per week? _____

How much coffee, tea, or cola do you drink per week? _____

How much alcohol do you drink per week? _____

Do you do any drugs? How much per week? _____

**Indicate painful areas. Rate on pain scale 1 (none) to 10 (worst).**