Health and Wellness of Central Florida

NEW CONSULT INFORMATION FORM

Please print clearly:

Name:_____ Date:_____

Address:_____ Apt.#_____

City:_____ State:_____ ZIP:_____

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:_____

Reason for your consultation: (brief explanation) _____

_____

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 _____

Office use only:

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Name:_____ Date_____

HISTORY:

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

_____

What would you like to accomplish with this consultation? _____

_____

Past Accidents or injuries:_____

Are you motivated to improve your health? If yes why? _____

If there was a single thing that you could change that would make you happy, what would it be?

_____

_____

The intention for this consultation is to discover if our holistic approach to health is the right fit for you. Should you choose to take the next step, another appointment will be scheduled to do an examination and further examine the root cause of your concern. This consultation is scheduled for 10 minutes only.

SIGNED:_____

DATE_____

Office Use Only: