Custom Care Therapy & Wellness, Inc.

New Patient Form

Full Name			Today's Date
___Male ___Female ___Child ___Adult ___Unmarried ___Married ___Widowed ___Divorced			
Street Address			Date of Birth
City	State	Zip Code	Age
Phone- Home	Cell		Work
Spouse's Name	Cell		Employer
Emergency Contact		Phone #s	
Family Physician			Phone
Referring Physician			Phone
How did you hear about our practice?			
Reason for today's visit			

Please check the appropriate box below for your current or past medical conditions.

☐ Yes ☐ No --Anemia
☐ Yes ☐ No --Asthma
☐ Yes ☐ No --AIDS/HIV
☐ Yes ☐ No --Artificial Joint
☐ Yes ☐ No --Bleeding Abnormality
☐ Yes ☐ No --Cancer
☐ Yes ☐ No --Chemical Dependency
☐ Yes ☐ No --Circulatory Disease
☐ Yes ☐ No --Congenital Heart Condition
☐ Yes ☐ No --COPD
☐ Yes ☐ No --Cortisone Treatment
☐ Yes ☐ No --Depression
☐ Yes ☐ No --Diabetes
☐ Yes ☐ No --DJD-Arthritis
☐ Yes ☐ No --Eating Disorder
☐ Yes ☐ No --Emphysema
☐ Yes ☐ No --Epilepsy
☐ Yes ☐ No --Headaches
☐ Yes ☐ No --Heart Disease/Attack
☐ Yes ☐ No --Hepatitis type_____
☐ Yes ☐ No --Herpes Virus
☐ Yes ☐ No --High Blood Pressure
☐ Yes ☐ No --Kidney Disease
☐ Yes ☐ No --Liver Disease or Jaundice
☐ Yes ☐ No --Multiple Sclerosis
☐ Yes ☐ No --Nausea/Vomiting
☐ Yes ☐ No --Organ transplant recipient
☐ Yes ☐ No --Osteoporosis
☐ Yes ☐ No --Pacemaker Type_____
☐ Yes ☐ No --Psychiatric Disorder
☐ Yes ☐ No --Rheumatoid Arthritis
☐ Yes ☐ No --Sinus Problems
☐ Yes ☐ No --Shortness of Breath
☐ Yes ☐ No --Skin Problems/Rashes
☐ Yes ☐ No --Stroke
☐ Yes ☐ No --Swollen Feet or Ankles
☐ Yes ☐ No --Thyroid Problems
☐ Yes ☐ No --Tuberculosis
☐ Yes ☐ No --Tumors/Growths
☐ Yes ☐ No --Unexplained Weight Loss/Gain
☐ Yes ☐ No --Weakness/Fatigue
☐ Yes ☐ No --STDs
☐ Yes ☐ No --Tobacco Use Amount_____
☐ Yes ☐ No --Alcohol Use Amount_____