INNOVATIVE Health
Chiropractic • Laser Therapy
Functional Medicine
2114 Schofield Avenue • Weston, WI 54476

FUNCTIONAL MEDICINE PATIENT INFORMATION

☐ New Patient
☐ Reactivate (1 yr)

Please fill out this form as completely as possible. In order for us to provide the very best care, it is important that we get a complete picture of your overall health.

Legal Name (*First, Middle, Last*):		Today's Date:
Street Address:		Home Phone: ☐ Preferred
City / State / Zip:		Work Phone: ☐ Preferred
Social Security #:	Birthdate:	Cell Phone: ☐ Preferred
Driver's license #:	Sex: ☐ Male ☐ Female	Cell Carrier: (for text reminders)
Ethnicity: ☐ Non-Hispanic ☐ Hispanic	Email:	

Race: ☐ White/Caucasian ☐ African American/Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaska Native
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: _____

Occupation:	Employer:
Primary Medical Doctor:	Medical Doctor Clinic & City:
Emergency Contact:	Emergency Contact's Phone:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name:
Spouse's Phone:	Spouse's Employer:

How Did You Hear About Us? (*Check all that apply*) ☐ I have been a past patient ☐ Referred by (name): _____
☐ Newspaper ☐ Radio ☐ TV ☐ Internet ☐ Yellow Pages ☐ Sign/Location ☐ Other: _____

REASON FOR VISIT: (Use back side of paper if necessary)

What is the primary reason you've come for a consultation? Please provide details including: when & why the problem started, what has been done to date, the results you've had, whether the condition is improving, worsening, or staying the same.

How has your condition impacted your daily life? Has it prevented you from performing or enjoying activities of daily living? What are some examples?

Are you experiencing any secondary health conditions? ☐ No ☐ If yes, please describe.

List current prescriptions, over-the-counter medications, and supplements: ☐ None

Name	Dosage *(mg, mL, …)*	Form *(Tablets, Caps…)*	How Often *(times per day, wk, mo)*	Duration *Chronic*	*As Needed*	*Unknown*
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			

List allergies ☐ None

Drugs, Medications (ADR):	Foods:
Environmental:	Other: (latex, animals...)

MEDICAL HISTORY

List major illnesses, injuries, falls, hospitalizations, accidents, or surgeries: ☐ None

Date	Condition(s)	Treating Doctor	Results
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications

Are you currently seeing any other healthcare professionals such as a dentist, massage therapist, acupuncturist, psychologist, etc? If so, please explain.

Use this space to add anything else you would like to share about your health concerns or that you think the doctor should know.

Please review this form to be sure your answers are accurate, and then sign below.

Patient Name (printed)

Date

X

Patient Signature

X

Parent/Guardian/Legal Representative Signature