

CLINICAL RECORD FORM

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

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

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Work (____) _____ Home: (____) _____ Cell: (____) _____

Health Plan ID#: _____ Subscriber S.S.#: _____ - _____ - _____

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: _____