Nutura Clinic New Patient Form

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential.

Last Name:_____ First Name:_____ MI:____ Date of Birth: _____

Home Address**:** _____
Street *City* *State* *Zip*

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Email Address: _____

Employer: _____ Employer Phone:_____

Marital Status: _____ Spouse Name:_____

Ethnicity:_____ Race:_____ Age:_____ Sex:____ Primary Language Spoken:_____

Insurance Information: *please bring your insurance card to the front office.*

Emergency Contact (EC) / Release of Information (ROI)- Please Check the Boxes that Apply:
Name of Person to Contact in case of Emergency or we may release information to:

Name:_____ Phone:_____ Relationship:_____ EC ROI

Name:_____ Phone:_____ Relationship:_____ EC ROI

Name:_____ Phone:_____ Relationship:_____ EC ROI

Current Symptoms/ Reason for Visit:	**Length of time:**
1.	
2.	
3.	

Are your Symptoms?

	Yes	No	When
Work Related?	____	____	_____
Injury Related?	____	____	_____
Did you stop working?	____	____	_____
Did you return?	____	____	_____

Please flip form over

→

Recent Testing? (Last 6 Months) **No** **Yes**

Test Name	Date
1.	
2.	
3.	

Current Symptoms: Please Check All that Apply

- ☐ Abdominal Pain
- ☐ Back Pain
- ☐ Blood in Urine
- ☐ Bloody/ tarry stool
- ☐ Bruise Easily
- ☐ Change in bowel habits
- ☐ Chest Pain
- ☐ Cold numb feet
- ☐ Constipation
- ☐ Convulsions/ Seizures
- ☐ Cough
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Dizziness/ Fainting
- ☐ Ear Infection
- ☐ Failing Vision
- ☐ Fatigue
- ☐ Fever
- ☐Foot Pain
- ☐ Frequent Urination
- ☐ Hair Loss
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Hives
- ☐ Hoarseness
- ☐ Indigestion/ Heartburn
- ☐ Insomnia
- ☐ Joint Pain
- ☐ Leg Pain
- ☐ Loss of Appetite
- ☐ Lumps/ Masses
- ☐ Memory Loss
- ☐ Moodiness
- ☐ Muscle Weakness
- ☐ Nausea/ Vomiting
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Nosebleeds
- ☐ Numbness/ Tingling
- ☐ Pain/ Bleeding during Sex
- ☐ Painful Urination
- ☐ Phobias
- ☐ Rashes
- ☐ Ringing in Ears
- ☐ Sexual Dysfunction
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Sore Throat
- ☐ Swollen Ankles
- ☐ Tooth/ Gum Trouble
- ☐ Tremors
- ☐ Urethral Discharge
- ☐ Varicose Veins
- ☐ Weight Loss

Patient Signature:_____Date:_____

Guardian Signature:_____Date:_____

Doctor Official Use Only: Patient Initials:_____DOB:_____Height:_____Weight:_____lbs