

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:

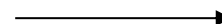
Length of time:

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

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

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Doctor Official Use Only: Patient Initials: _____ DOB: _____ Height: _____ Weight: _____ lbs