

DATE _____

NEW PATIENT QUESTIONNAIRE

LN/08

Please accurately complete the entire form for our records. **PRINT CLEARLY**

Name: _____ D.O.B. _____

Address: _____

City/State/Zip: _____

Phone(s): C: _____ W: _____ H: _____

e-mail: _____

Emergency Contact: _____

PRESCRIPTION MEDICATIONS:

Name of Med	Dosage	Frequency
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SUPPLEMENTS:

Brand	Name of supplement	Dosage	Frequency
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OVER THE COUNTER MEDICATIONS:

Brand Name	Type of Product	Dosage	Frequency
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____