Clinical Record Form

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

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

Address: _____

City: _____ State: _____ Zip: _____

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

Health Plan or other Patient ID#:_____

Employer/School: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Emergency Contact: _____ Telephone: ( ) _____

Parent/Guardian (if relevant): Name: _____ Telephone: ( ) _____

Address: _____ Telephone: ( ) _____

Current Medical Conditions: _____

_____

_____

Current Medications, Herbal Supplements or Vitamins: _____

_____

_____

Allergies/Adverse Reactions to Treatment: _____

_____

_____

Primary Care Physician Name: _____

Address: _____Telephone: ( ) _____

Reason for Evaluation Today and Presenting Problem: _____

_____

_____

_____

Past and Present Use of Cigarettes, Alcohol, and Other Substances: _____

_____

_____

_____

Patient/s Signature: _____ Date: _____

Patient/s Signature: _____ Date: _____

Clinician Name, Degree/License_____ Date: _____