

ATLAS DRUG AND NUTRITION CENTER

*"a neighborhood tradition for over 70 years"
corner of 85th and Kennedy Blvd*



New Client Information

Please print clearly

Name: _____ Date: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Shipping Address: _____

Home Phone:() _____ - _____ Work Phone:() _____ - _____

Cell Phone:() _____ - _____ Email Address: _____

Easiest place to reach you: _____ May we leave a message? Y/N

Referred by: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Current Complaints (reason you are here): _____

Current medications/drugs being taken with dosages: _____

Are you currently under the care of a physician or other health care professionals? If yes, please give name: _____

Are you currently taking vitamins, herbs or nutritional supplements? If yes, please list:

Personal Habits: Do you use the following and if so, how much?

Cigarettes _____ Coffee _____ Alcohol _____
Soda _____ Sugar _____ Non prescription drugs _____

HEALTH HISTORY:

List any major illnesses, injuries, surgeries (with approx. dates):

Any major scars or body piercings (please list): _____

of pregnancies: _____ Are you currently pregnant: Y/N

Marital status (please circle): Single, Married, Divorced, Widowed

Name of Spouse or Partner: _____

Describe health of Spouse or Partner: _____

of Children: _____ Any concerns or health issues (if so, please list):

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes /
Heart / Stroke / Other: _____

Any household pets or other animals you or family members are in close contact with:

How can we help you? _____

SIGNED: _____ **DATE:** _____