JourneyFit, LLC
Michelle Morath, DN

505.550.8322

Last Name: ____________ First Name: ____________ Date: ________

Address: ______________________________ Zip Code: ________

Home phone number: ______________ Cell Number: ______________

Email Address: ______________________________

Age: ________ DOB: ________ Occupation: ______________

Emergency Contact: ______________________ Phone: __________

How did you hear about the clinic? ______________________

Are you currently receiving health care? ________ Name of Physician: ______________

Condition being treated: ______________________________

What are your most important health concerns?

1) ______________________________

2) ______________________________

3) ______________________________

Please list tested or suspected allergies or sensitivites and their related symptoms:

Foods: ______________________________

Seasonal: ______________________________

Pets: ______________________________

Drug/other: ______________________________

Current Medications & Supplements: Please list any prescription medications or over-the-counter medications you are taking.

____

____

Do you have a current medical condition? (ex: epilepsy, pregnancy)? ______________

Do you smoke? ________

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the items listed on the New Patient Information form.

Signature: ______________________ **Date:** ____________

(If under the age of 18, must be signed by Parent or Legal Guardian.)

3901 Georgia St. NE, Bldg F Albuquerque, NM 87110
mmorath@journey-fit.com 505.435.9735 (f)