

Middletown Wellness Center

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE CALL: (215) 741-0700
WHEN FINISHED, PLEASE SIGN, DATE, AND FAX THIS FORM TO: (215) 750-2661
OR MAIL TO: Oxford Square at Oxford Valley 380 Middletown Blvd. Ste 706 Langhorne, PA 19047
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Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address _____

Home Phone (____) ____-____ Work Phone (____) ____-____

e-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height ____ Weight ____

Overall Health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief Complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint: _____

Other complaints or problems: (use separate sheet if needed) _____

Current medications/drugs being taken: (use separate sheet if needed) _____

Are you currently under the care of a physician or other health care professionals? (If yes, please give name and date of last visit)

Nutritional supplements your are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

Office use only:

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Name _____ Date _____

HISTORY:

List any major illnesses (with approx. dates): _____

List any surgery or operations with approx. date: _____

Past Accidents or injuries: _____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any family history of serious illness (circle those which apply): Cancer / Diabetes / Heart /

Other _____

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

What can we do to make you happier? _____

SIGNED: _____ DATE: _____