CLIENT INFORMATION (Confidential)

Name: **Date:**

Address:

Daytime phone: **Evening phone:** **E-Mail:**

Emergency contact:

Date of Birth:

How did we hear from you? Who referred you?

Briefly describe your health concern(s).

Please list previous/other illnesses, injuries, surgeries and approximate dates:

Please list any chronic condition, e.g., headaches, thyroid problems, heart or kidney condition, indigestion, insomnia, infections and any medication(s) you are currently taking for each one:

Do you have any burns, fresh scars, bruises, eczema, or moles? [ ] yes [ ] no
If yes which and where are they? How long have you had them?

Are you wearing contact lenses? [ ] yes [ ] no

For Women:
Are you menstruating today? [ ] yes [ ] no

Is there any possibility that you are pregnant? [ ] yes [ ] no

Are you post-menopausal? [ ] yes [ ] no

Please list your supplements:
Vitamins:

Minerals:

Antioxidants:

What is your daily intake of…?
Pure water_____8-oz glass
Fruit juice _____8-oz glass
Soft drinks_____8-oz glass
Tea/coffee_____8-oz glass
Alcohol _____5-oz glass

Briefly describe your diet:

Other Health/Life Style Facts:

Are your bowel movements:_____times/day_____times/week

How often do you exercise? [ ] daily [ ] weekly [ ] occasionally [ ] never

What types of exercise do you engage in?

Rate the level of stress in your life right now on a scale of 1-10 (1=none 10= 100%) _____