New Client Information Form

Name: _____

Address: _____Apt: _____

City: _____ State: _____ Zip: _____

Shipping address: _____

_____

Home phone: _____ Work phone: _____

Email: _____

Referred by: _____

Occupation: _____

Date of birth (mm/dd/yyyy): _____ Height:_____ Weight:_____

Overall health: _____

Chief complaint (reason you are here): _____

_____

Previous treatment for this complaint: _____

_____

Current medications/drugs being taken: _____

_____

Are you currently under the care of a physician or other health care professionals? Yes No

(If yes, please give name and dates of last visit): _____

_____

Nutritional supplements you are taking: _____

_____

Do you smoke? Yes No Drink coffee? Yes No Drink alcohol? Yes No

If yes, please indicate how much (daily).

Cigarettes: _____ Coffee: _____ Alcohol: _____

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Name: _____Date: _____

HISTORY:

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

_____

List any surgeries (with approx. dates): _____

_____

Past accidents or injuries: _____

_____

Marital Status: Single ___ Married ___ Widow ___ Name of spouse: _____

Describe health of spouse: _____ # of children: _____

Name of Child	Age	Sex	Any physical condition or concerns?
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

Any family history of serious illness (check those that apply)

___ Diabetes ___ Heart disease ___ Cancer Other: _____

List any household pets or other animals you or your family are in close contact with:

_____

What can we do to make you happier? _____

Signed: _____ Date: _____

Goals!

___ Better Moods ___ Hormone Balancing ___ Flat Stomach ___ Less Gas

___ Weight Loss ___ Clear Headedness ___ Pain Relief ___ Better Sleep

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