

NEW CLIENT INFORMATION FORM

Please Print Clearly:

Name _____ Date _____

Address _____ Appt. # _____

City _____ State _____ ZIP Code _____

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

E-Mail _____

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

REFERRED BY: _____

Marital Status: S M D W Name of Spouse: _____

Describe Health of Spouse: Excellent Good Fair Poor Other: _____

Number of Kids _____ # Kids Living at Home: _____

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

Do you smoke or drink alcohol? (If yes please indicate how much)
 Alcohol: Yes No How Often? _____
 Cigarettes: Yes No Packs Per Day _____ Cigars: Yes No # Per Day _____

Occupation _____ Employer _____

Overall Health: Excellent Good Fair Poor Other: _____

List any surgery or operations with approx. date: _____

Any Allergies to Medications:	List Any Major Illnesses (Diabetes, Hypertension etc.)
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Current Medications/ drugs being taken:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Please complete the other side of this page.

Office use only: New Client Information Form: FILE: Left side of chart under patient information tab.

Nutritional supplements you are taking:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

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

Previous Treatments for this complaint _____

Other complaints or problems: _____

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

1. _____
2. _____
3. _____

HISTORY:

Any family history of serious illness (circle those which apply):
Cancer / Diabetes / Heart / High Blood Pressure Other: _____

Any food or environmental allergies (dust pollen grass etc.) _____

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

What can we do to make you happier? _____

Please note all services are to be paid in full at the time of your visit. We do not allow any returns on all supplements as we are unable to control the temperature of these products once they leave the office.

All sales are final.

Signed: _____ Date: _____

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