New Client Information

Please Print Clearly

Name: _____ **Date**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Cell Phone: _____ **Home/Work Phone**: _____

Email:_____

Date of Birth: _____ **Age**: _____ **Sex**: M/F **Height**: _____ **Weight**: _____ **# of Children**:_____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Occupation: _____ **Employer**: _____

Is your job associated with potentially harmful chemicals (pesticides, radioactivity, solvents), **health and/or life threatening activities** (fireman, etc.) or **are you around computers, power lines/towers, cell phones**?

_____

How did you hear about us or who were you Referred By: _____

Chief Complaints (In order of concern):

1: _____ 2: _____

3: _____ 4: _____

Previous treatment for complaint: _____

Current medications/drugs:

_____

_____

Current supplements:

_____

_____

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

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness	Injury Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all scars: _____

Any family history of serious illnesses? _____

_____

List any household pets or animals you are in close contact with: _____

Are you recovering from a cold or flu? _____ **Are you pregnant?** _____

Do you smoke, drink coffee or alcohol? If yes, indicate how often per week:
Cigarettes: _____ **Coffee**: _____ **Alcohol:** _____

Sleep: Avg. Hrs/night? _____ **What time do you eat dinner?** _____ pm/am

Do you eat/snack between dinner and going to bed? Y/N **What time do you go to bed at night?** _____ pm/am

What time do you set your alarm clock? _____ pm/am **Do you watch TV before bed at night?** Y/N

How much water do you drink daily _____oz

Allergies (list all that apply): _____

Do you have pacemaker or other surgical implant? Y/N What?_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? Y/N If so, Why?

_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture
❑ conventional drugs ❑ other: _____

Do you experience any of these general symptoms <u>EVERY DAY</u>?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Signature (including Parent/Guardian Signature if under 18**)**: _____ **Date**: _____