New Client Information

Name_____ **Date**_____

Address_____

City_____ **State**_____ **Zip**_____

Home #_____ **Cell#**_____ **Work#**_____

E-Mail_____ **Occupation**_____

Referred By_____ **B-Day**_____

Age:	Wt:	Ht:	BP:

What is your main complaint or area of interest?

_____

Family History (check all that apply):

Stroke_____ **Diabetes**_____

High BP_____ **Weight Problems**_____

Depression_____ **Ulcer**_____

Heart Disease_____ **Psoriasis**_____

Arthritis (RA or OA)_____ **Glaucoma**_____

Cancer___**Type?**_____ **Family Side:** ♀_____♂_____

New Client Information

Personal History (check all that apply):

¨ Arthritis o RA o OA ¨ Stroke ¨ High Cholesterol o How High?_____ ¨ High Blood Pressure o How High?_____ ¨ Diabetes o Metabolic Syndrome o Insulin Resistance ¨ Low Blood Sugar ¨ Chronic Fatigue o Fibromyalgia o Multiple Chemical Sensitivities o Infectious Mononucleosis ¨ Frequent Colds/Flu ¨ Herpes/HPV ¨ Cold Sores ¨ Cancer o What type?_____ o Chemo?_____ o Rads? o Steroids? ¨ Surgeries o What type?_____	¨ Thyroid Problems o Hypothyroidism o Hyperthyroidism ¨ Headaches o Chronic Tension o Migraines o Cluster o Hormonal ¨ Food Allergies o To What?_____ ¨ Seasonal Allergies o To What?_____ ¨ Medication Allergies o To What?_____ ¨ Sleep Problems ¨ Forgetfulness ¨ Hot Flashes ¨ PMS ¨ Birth Control Pills/ Hormones ¨ Weight Problems ¨ Constipation ¨ Diarrhea ¨ Abdominal Cramping/ Bloating ¨ Yeast Infections ¨ Low Libido ¨ Ulcers

What Medications and Dosages are you taking? List all please:

_____

_____

What Vitamins and herbal supplements are you taking? List all please:

_____

_____

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Do you eat, drink, or use (circle all that apply):

Antacids	Protein Drinks	Appetite Suppressants
Aspirin	Alcohol	Coffee
Tylenol	Tap Water	Decaf Coffee
Ibuprofen	Bottled Water	Diet Soda
Laxatives	Tea	Soda
Refined Sugars	Candy	White Bread
Margarine	Butter	Fast Foods
Chewing Gum	Fried Foods	Chips
Salt (w/out tasting)	Tobacco	Cigarettes
Artificial Sweeteners (Blue, Pink, Yellow)		Coffee Creamers

List any food aversions and/or foods you dislike:

_____

Do you get noticeably irritated, weak, or lightheaded if you haven't eaten in a while?

_____

Do you crave certain foods?_____What foods? Sweets? Chocolate? Bread/Pasta? Fried Foods? Meat? Other?

Foods? Alcoholic drinks? Sodas/Diet Sodas?

_____

Are you:

Under excessive amounts of stress_____ at home_____ at work_____

Physical Stress_____ Mental Stress_____

Exposed to chemicals regularly_____Type_____

Exposed to smoke regularly_____

How often do you have bowel movements?_____per day/ week/ month

Urinate?_____per day

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How is your dental health? Prone to Cavities? Gum Disease? Bleeding Gums?

_____

Are your nails week or brittle?_____

Average Sleep per night? _____

Any sleeping problems? _____

To what extent will you commit to achieving better health?

Little_____ **Moderate**_____ **Major**_____ **Extreme**_____

Is there anything else about either your history or your current condition that you feel is important to mention?

_____

_____

_____