New Client Information

Please Print:

Name: _____ Primary Phone: _____

Other Phone: _____ Email:_____

Address: _____

City, State, Zip: _____

DOB: _____ Age: _____ Sex: M F Marital Status: S M D W

Height: _____ Weight: _____ SSN: _____

Occupation: _____ Work Phone: _____

Employer: _____

Name of Spouse: _____ Number of children: _____

Emergency Contact: _____ Relationship: _____

EC Phone: _____ Address: _____

Family History

Parents Living: Father age: _____ Mother age: _____

Brothers: _____ Sisters: _____

Family history of: Cancer _____ Diabetes _____ Asthma _____ Allergies _____

Mental Disease _____ Lung Disease _____ Arthritis _____

Other: _____

Personal History

Childhood diseases: Measles _____ Mumps _____ Chicken Pox _____

Unusual childhood diseases: _____

Do you smoke? Y N Do you drink coffee? Y N Do you drink alcohol? Y N

List Prescribed Medications:

_____

_____

_____

List Vitamins: _____

List Herbals: _____

List Regular Exercise: _____

Hobbies: _____

List Significant Injuries/Illnesses & Dates: _____

_____

_____

List Operations & Dates: _____

_____

Do you have back trouble? Describe: _____

List Known Allergies & Reactions: _____

_____

Do you get anaphylactic reactions to any substance? _____

Last Physical Exam: _____ Findings: _____

Are you under a lot of stress? If yes, please explain: _____

_____

Do you have difficulty concentrating or forgetfulness? _____

Females: Do you experience discomfort with your menstrual cycle? Explain: _____

_____

What is your chief complaint? _____

_____

How long have you had this condition(s)? _____

What do you think caused this condition (s)? _____

_____

List any other health practitioners you are seeing at this time & reasons (include medical doctor,

massage, acupuncture, chiropractor, etc.):_____

_____

Diagnosis by your primary doctor: _____

List all food & beverages taken more than 3 times per week: _____

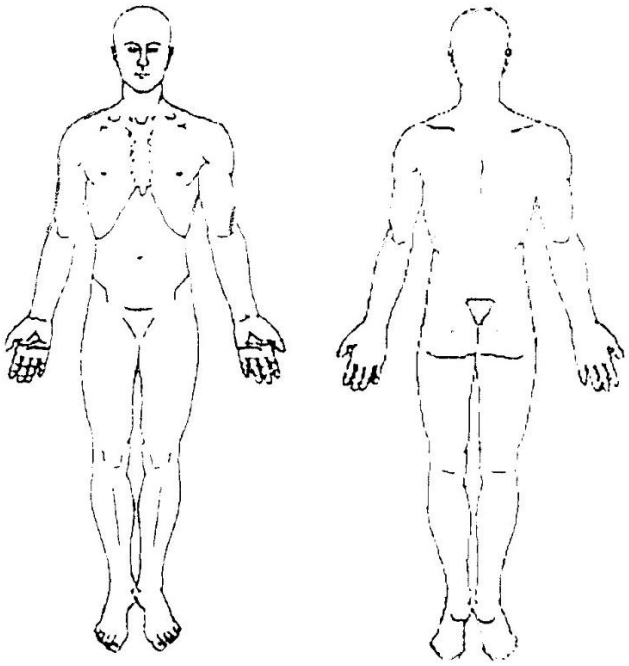
_____

_____

Please circle all that apply to you:

Frequent childhood illness	Hypoglycemia	Excess sweating	Water retention
Frequent colds/sore throat	Insomnia	Numbness	Bleeding gums
Sinusitis	Fatigue	Muscle spasms	Dry mouth
Allergies	Urinary difficulty	Aches/pains	Cold sores
Lymph nodes enlarged	Urinary frequency	Cold hands/feet	Dental problems
Lymph nodes removed	Sugar cravings	Cold body temperature	Poor vision
Shortness of breath	Food cravings	Hot body temperature	Eye pain/redness/dryness/itching
Asthma	Excess appetite	Hot flashes	Seeing spots
Chronic cough	Reduced appetite	Night sweats	Ear pain
Nose bleeds	Stomach pain	Hair loss	Ringing in ears
Itching	Excess weight gain	Hair dry/brittle	Clogged/popping ears
Hives	Excess weight loss	Premature greying	Varicose veins
Eczema	Intestinal gas	Brittle nails	Hypertension
Acne	Bloating	Mood swings	Hypotension
Skin rashes	Constipation	Sad/depressed	High cholesterol
Dry skin	Diarrhea	Anxiety	Mitral Valve prolapse
Headaches	Acid reflux	Irritability	Heart conditions: (specify)
Convulsions	Hiatal hernia	Panic attacks	_____
HIV/AIDS	Excess Thirst	Rapid heartbeat	Blood Pressure _____/_____
Hepatitis A/B/C	Latex allergy		
Venereal diseases	Diabetes	Other:	

Please indicate on figures below where you are currently experiencing pain or discomfort:



PAYMENT IN FULL IS DUE AT TIME OF SERVICE.

I HEREBY CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE AND COMPLETE.

_____ _____

Member Signature **Date**

_____

Print Name

_____ _____

Dependent Name **Relationship**