CONFIDENTIAL CLIENT INFORMATION

Name:				Telephone:			
Address:			Cell Phone:				
City/State/Zip:			E-Mail:				
Date of Birth:			Occupation:				
Spouse:			Referred By:				
Check All Tha	at Apply:						
[] Arthritis	[] Backaches	[] Headaches	[] Hernia	[] Dige	stive Disorder		
[] Numbness				matic Fever			
[] Diabetes				Cholesterol			
[] Asthma	[] Cancer	[] Sinus Trouble					
I Use The Following:							
[] Herbs [] Vitamins [] Homeopathies [] Essential Oils							
[] Do You Use Any Particular Brands?							
Have you been treated for any health condition in the past year? [] Yes [] No Describe:							
Purpose of this	appointment:						
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List any drugs of	r medications you	are currently takin	ng :				
CONFIDENTIAL CLIENT INFORMATION							
		CONFIDENT	TIAL CLIE	NT INFORI	MATION		
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Name:		CONFIDENT	TIAL CLIE	Telephone:	MATION		
Address:		CONFIDENT	TIAL CLII	Telephone: Cell Phone:	MATION		
Address: City/State/Zip:		CONFIDENT	TIAL CLII	Telephone: Cell Phone: E-Mail:	MATION		
Address: City/State/Zip: Date of Birth:		CONFIDENT	TIAL CLII	Telephone: Cell Phone: E-Mail: Occupation:	MATION		
Address: City/State/Zip: Date of Birth: Spouse:		CONFIDENT	TIAL CLII	Telephone: Cell Phone: E-Mail:	MATION		
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