CONFIDENTIAL CLIENT INFORMATION

Name:	Telephone:
Address:	Cell Phone:
City/State/Zip:	E-Mail:
Date of Birth:	Occupation:
Spouse:	Referred By:

Check All That Apply:

[ ] Arthritis [ ] Backaches [ ] Headaches [ ] Hernia [ ] Digestive Disorder
[ ] Numbness [ ] Nervousness [ ] Neuritis [ ] Dizziness [ ] Rheumatic Fever
[ ] Diabetes [ ] Anemia [ ] Heart Trouble [ ] High/Low BP [ ] High Cholesterol
[ ] Asthma [ ] Cancer [ ] Sinus Trouble [ ] Root Canals [ ] Amalgam Fillings

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:
List any drugs or medications you are currently taking?

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