NEW CLIENT INFORMATION SHEET

Date: ____________________

Last Name: __________________________________ First Name: __________________________

Street Address: ____

City:________________________________ State: ____________ Zip: ____________________

Phone: (_______)_____________________ Email: _______________________________________

Birthdate: ____________________ Marital Status: _________ Number of children: __________

Major Complaint: ____

____

Please check whatever applies from the list below:

___ No energy
___ Headaches
___ Backaches
___ Muscle Problems
___ Bad Digestion
___ Heart Problems
___ High Blood Pressure
___ Low Blood Pressure
___ Depression
___ Complexion Concerns

___ Low Appetite
___ High Appetite
___ Hiatus Hernia
___ Sexual Dysfunction
___ Pregnant
___ Chronic Indigestion
___ Allergies
___ Gas/Bloating
___ Asthma
___ Female Concerns
___ Constipation

___ Diarrhea
___ Cold Hands/Feet
___ Swollen/Painful Joints
___ Frequently Sick
___ Heartburn
___ Insomnia
___ Cannot Relax
___ Low/High Blood Sugar
___ Male Concerns

If applicable, please list what your physician has told you about your suspected condition(s):

____

____

Current medication(s):

Name	For what?	How long taking it?
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________

Level of Exercise: ____

Please list any herbs, vitamins, or other supplements you take: ____________________________

____

Have you had any major changes in your diet in the last four months? ___ If yes, please explain:

____(over)

List any major surgeries you have had in your lifetime:

___

___

Have you received any injections/vaccines/or shots in the last five years? Y / N

Please check if you have ever received any of the following vaccinations/injections/or shots, and if known, the year administered:

___ ______Hep A
___ ______ Hib/Hep B
___ ______ DPT/DTaP
(diphtheria, pertussis, tetanus)
___ ______ MMR (measles, mumps, rubella)
___ ______ Varicella (chickenpox, shingles)
___ ______ Tetanus
___ ______ RSV

___ ______Pneumonia
___ ______Influenza
___ ______HPV
___ ______Meningococcal
___ ______ Pneumococcal
___ ______ Other
____ _______COVID (Please specify which type and how many): ____

How many bowel movements do you have per day? ___ Any problems? ___

___

What is your typical breakfast? ___

Please indicate the frequency of any of the following:

___ ______ Tobacco
___ ______ Alcohol
___ _______ Soda/Pop
___ ______ Coffee

___ ______ Food Cravings
___ ______ Marijuana
___ ______ CBD
___ ______ Other Recreational Drugs

IMPORTANT: By signing below, I understand that the suggested nutritional program and dietary information is not intended as primary therapy for any disease or symptom. My intention is to find a good nutritional program that will assist me in changing my habits and establishing a new lifestyle in order to build good health naturally. I understand that this dietary health program is not for the diagnosis, cure, mitigation, treatment or prevention of disease; this is an adjunctive schedule of nutrients solely provided to upgrade the quality of foods in my diet in order to supply good nutrition for supporting the physiological and biochemical processes of the human body.

I understand that the natural health consultant I am visiting is not a medical doctor and does not treat or diagnose medical conditions; that this is not a replacement for medical counseling; that I have a medical condition, I will seek a qualified medical professional.

I understand that it is my personal decision whether to follow the natural health suggestions offered.

___ Signature ___ Date

Please read and sign attached Client Agreement form.