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.*