New Client History Form

Name *

First Name Last Name

Date *

Month Day Year

Date of Birth *

Sex *

Male Female

Phone Number *

Please enter a valid phone number.

Email *

example@example.com

Address *

Street Address

Street Address Line 2

How did you hear about us?

Facebook
Twitter
Instagram
Website
Other

If someone referred you, we would like to say thank you

Medical History

Do you have any chronic medical conditions which we should know about? *

YES
NO

If so, please list

Do you have any allergies to latex, medications, herbal or natural supplements? *

YES
NO

If so, pleas list

Do you have, or have you had, any changes in medical history recently? *

YES
NO

If so, pleas list

Do you have hearing aids, Pacemaker or hormone pellets (where) or metal/medical devices? *

YES
NO

If so, pleas list and notate where the device is located

Do you have Type 1 or Type 2 Diabetes? *

No Type 1 Type 2

Do you have, or have you had Cancer in the leas 12 months? *

YES
NO

If yes, are you on chemotherapy?

YES
NO

Do you have a thyroid problem *

YES
NO

Do you have High Blood Pressure? *

YES
NO

Do you have Cardiovascular Conditions? *

YES
NO

Women Only

Are you currently pregnant, or nursing?

YES
NO

List all current medications including vitamins:

Medical History Continued

Please give current weight and height

What is your Ethnic Background? *

Do you have Abnormal Skin Sensation? *

YES
NO

Do you have Epilepsy? *

YES
NO

Do you have Infections? *

YES
NO

Do you have Tumors? *

YES
NO

Do you have Skin Diseases? *

YES
NO

Do you have Thrombosis/Phlebitis? *

YES
NO

Do you have Autoimmune Disease? *

YES
NO

Have you had your Gallbladder Removed? *

YES
NO

Date of Gallbladder Removal

Day Year

History of Gallstones? *

YES
NO

History of Liver Problems? *

YES
NO

History of Colon Problems including protruding/distended belly *

YES
NO

Are you currently dieting? *

YES
NO

Please name/explain current diet

Have you had any surgeries? *

YES
NO

Please explain surgeries and list dates:

Nutritional Questionaire

Water: How many glasses a day? *

Coffee: How many cups a day? *

Alcohol: How much per week? *

Do you eat fast food? *

YES
NO

What type of fast food?

How often and what type do you eat fast food?

Do you drink Soda or Carbonation? *

YES
NO

Type of Soda or Carbonation?

Do you use Tabacco? *

YES
NO

Type of Tabacco and how often

Do you use Recreational Drugs *

YES
NO

Type of Narcotic and how often

Date *

Month Day Year