Health Improvement Program

New Client Personal Information

Date: _____

Name: _____ **E-Mail Address:** _____

_____

Street Address City State ZIP

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

D.O.B. _____ **Age:** _____ ☐ **Male** ☐ **Female** **Ht.**_____ **Wt.** _____

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** **# of Children, if any:** _____

We would like to express our THANKS to *(whom)*_____ **for referring you!**

How would you describe your overall health? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Chief Complaint: _____

_____

_____

Previous Treatment(s) for this complaint: _____

_____

_____

Any other complaints or problems? _____

_____

_____

Current Medications / Drugs taken: _____

_____

Drug Allergies, if any: _____

Current Supplements [vitamins / minerals / herbs / other nutrients]: _____

_____

_____

Are you currently under the care of a physician or other healthcare professional for any of these complaints or problems? ☐ **Yes** ☐ **No**

If yes, please provide the name(s): _____

_____

_____

DOCTOR'S COMMENTS: _____

_____

_____

_____

_____

_____

_____

Name _____

HISTORY

List any major illnesses *[with approximate dates / ages]***:** _____

_____

List any major surgeries *[with approximate dates / ages]***:** _____

_____

List any prior accidents / injuries *[with approximate dates / ages]***:** _____

_____

_____

Family History of serious illness(es): _____

_____

_____

LIFESTYLE

Diet	☐ **Mostly "Junk Food"**	☐ **Mix of "Junk Food" & Healthy Foods**			☐ **Mostly Healthy Foods**
Water Consumption	☐ **Do Not Drink Much Water**		☐ **Drink Tap Water**		☐ **Drink Bottled or Filtered Water**
Alcohol Consumption	☐ **Non-Drinker**	☐ **Light Drinker**	☐ **Moderate Drinker**		☐ **Heavy Drinker**
Coffee / Caffeine Consumption	☐ **No Coffee / No Caffeinated Drinks**		☐ **Minimal [some]**	☐ **Moderate [avg.]**	☐ **Heavy**
Exercise ☐ **None**	☐ **Some / Occasional**	☐ **Moderate**		☐ **Regular / Frequent**	☐ **Athletic Training**
Sleep	☐ **Enough**	☐ **Restful**	☐ **Not Enough**	☐ **Restless**	☐ **Insomnia**
Stress ☐ **None**	☐ **Some / Occasional**	☐ **Moderate**		☐ **Regular / Frequent**	☐ **Overwhelming**
Smoking	☐ **Non-Smoker**	☐ **Light Smoker**	☐ **Moderate Smoker**		☐ **Heavy Smoker**
Exposure to Air Pollution / Toxic Fumes	☐ **None**	☐ **Some / Occasional**	☐ **Moderate**		☐ **Regular / Frequent**
Animal / Pet Contact	☐ **None**	☐ **Some / Occasional**	☐ **Moderate**		☐ **Regular / Frequent**

What can we do to make you happier? _____

_____

_____

FINANCIAL AGREEMENT

I understand that all services that are rendered are to be compensated on a cash basis [that is cash, checks, or credit cards are accepted]. I acknowledge that the services plus any recommended nutritional supplements will not be submitted, reported, nor processed through any third party payer / insurer. Unless other arrangements have been made and approved [such as my participation in a Pre-Paid Plan], I agree to pay for each visit at the time of service.

_____ _____

Signature **Date**