Confidential Client Information

Name ______________________________________Date ________________

Address____

City/State/Zip____

Phone (primary) ______________________ (other)______________________

Email Address____

Date of Birth____

Marital Status _____________________#of Children_____________________

Occupation____

Name of Spouse/Partner____

Referred By____

Circle all that apply:

Dizziness	Joint Injury	High/Low Blood
Backaches	Osteoporosis	Pressure
Numbness	Pregnant	Mercury/Amalgam
Hernia	Recent Surgery	Fillings
Neuritis	Skin Conditions	Digestive Disorder
Cancer	Seizures	Nervousness
Root Canals	Headaches	Heart Trouble
Arthritis	Diabetes	Sinus Trouble
AIDS/HIV	Asthma	Rheumatic Fever
Bruise Easily	Anemia	High Cholesterol
Numbness & Tingling		

Have you been treated for any health condition in the past year? ______________

Describe____

Purpose of this appointment____

List any drugs that you are taking: ______________________________________

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