CLIENT INFORMATION AND STATEMENT   DATE:_____________

Name:____________________ Phone:H)________________C)____________

Street Address:____

City:____________________________ State:_______ Zip Code:__________

Email:____________________________ Birthdate:______________ Age:____

HEALTH INFORMATION

1. Have you ever had or been diagnosed as having problems with any of the following? (Please explain)

❒ Anemia________________________ ❒ Arthritis______________________
❒ Diabetes_______________________ ❒ Heart(high BP?)_______________
❒ Prostrate______________________ ❒ Nerves________________________
❒ Thyroid________________________ ❒ Skin__________________________
❒ Gall Bladder____________________ ❒ Tumors_______________________
❒ Spleen_________________________ ❒ Ulcers________________________
❒ Kidneys________________________ ❒ Fainting______________________
❒ Hypoglycemia___________________ ❒ Ovaries_______________________
❒ Throat_________________________ ❒ Breast________________________
❒ Bladder(infections?)_____________ ❒ Pancreas______________________
❒ Cancer_________________________ ❒ Digestion(gas,bloating,acid)______
❒ Lungs__________________________ ❒ Bleeding______________________
❒ PMS________Last Cycle:_________ ❒ Asthma________________________
❒ Epilepsy_______________________ ❒ Colon_________________________
❒ Spine/Back_____________________ ❒ Edema_________________________
❒ Liver__________________________ ❒ Circulation____________________
❒ Stomach________________________ ❒ High Blood Pressure____________
❒ Alzheimer's_____________________ ❒ Hay Fever/Allergies_____________
❒ Hemorrhoids____________________ ❒ Constipation___________________
❒ Parasites_______________________ ❒ Weight(Obesity)________________
❒ Yeast Infections/Fungus____

2. Occupation:____

3. Are you allergic to any food or medication?__________________________

4. Are you pregnant?_______ If so, how many months?________________

5. Are you experiencing cycle irregularities or menopause problems?
Explain:____

6. What conditions are you presently under a physician's care for?_________
____

7. Please list any medications you are taking and for what conditions:______
____

8. Are you experiencing any pain, cramping, spasms, sharp, &/or dull pain?
Explain:____

9. Please tell us how you learned of our service:____________________

10. List all nutritional supplements you are taking:____________________

____

DIETARY ANALYSIS

1. What do you typically eat, including snacks, for the meals listed below

   Breakfast:______________________________________

   Lunch:____

   Dinner:____

2. What percent of your total dietary intake consists of raw fruits & vegetables?
____

3. How many bowel movements do you have per day or week?__________

4. Does it take a lot of pressure when eliminating (dry and firm)?________
   If not, are they loose stools?____________________________

5. Do you ever smell ammonia in your urine?______________________

6. What foods do you crave, (sweets, breads, salty snacks, other)?________
____

7. Does your tongue have a white coating?________________________

8. Do your fingernails grow on a weekly basis, (brittle/cracking appearance)? ____

9. Are you a regular user of sleeping pills, marijuana, tranquilizers, painkillers, etc?
____

10. Have you ever used heroine, cocaine, LSD, PCP, etc?_______________

11. Do you drink more than 2 servings of alcohol in one sitting?_________

12. Have you considered committing suicide?________________________

13. Have you ever taken Hormone Replacement Therapy?_______________

14. Have you ever suffered from depression or lack of motivation?________
    Explain neurobehavioral symptoms:____________________________

____

15. Other health problems not listed:______________________________

____

LIST 2-3 GOALS OR HEALTH COMPLAINTS: (Use reverse side of paper if needed)

Signature:______________________________ Date:____________________