

## CLIENT INFORMATION

Date: \_\_\_\_\_ Client Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell: \_\_\_\_\_ Wk: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please state your primary health complaints: \_\_\_\_\_

Is there anything about your health history that you feel is important for the practitioner to be aware of?

Have you ever tested positive for any of the following?

HIV     Tuberculosis     Hepatitis (What type?)     Mononucleosis     Epstein Barr

To better serve you, please check if you have experienced any of the following?

Asthma                                       Fainting/Dizziness                                       Addiction  
 Stroke/Heart Attack                       Low Blood Sugar                                       Panic Attacks  
 Seizures                                       Drug/Alcohol Abuse                                       Others \_\_\_\_\_

## ILLNESS INJURIES SURGERIES

Please list all significant illnesses, injuries and surgeries since birth.

INCIDENCE

APPROXIMATE AGE OF OCCURENCE

The above disclosed information shall remain confidential.